JB Pritzker, *Governor*

Illinois Department of Human Services

Grace B. Hou, *Secretary*

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MEMORANDUM

TO: **Mayor-Elect Lori Lightfoot**

FROM: **Grace Hou, Secretary, Illinois Department of Human Services (IDHS)**

DATE: **April 18, 2019**

Congratulations and thank you for inviting me to be a part of your transition team. It has been an honor and a privilege to work with you in our previous roles, and I look forward to our continued partnership as full-time public servants.

We have important work ahead, as you know, but as you set forth your values of equity, transparency, accountability, diversion and inclusion, and transformation – I am heartened and inspired as those are the same words that we have also chosen to guide our work at the state. As you know, these words are more easily spoken than acted upon. Like you, I am committed to action.

IDHS touches the lives of 1 in 3 people in Illinois directly – I would say that most of us, maybe even all of us know someone who depends on DHS and its community partners to go to work, to eat, to nourish their children, to grow and develop, to lead healthy lives, and to recover and restore. IDHS is the agency to ensure basic human needs are met so that people in Illinois can lead lives with dignity.

As the reach of IDHS is so vast with so many points of intersection with the City of Chicago, I can not only identify one objective to focus our future partnership. Rather, I commit to you open communication, a spirit of learning and exploration, and honesty as we maximize opportunities and address shared challenges.

Thank you.

TO: Mayor-Elect Lori Lightfoot
FROM: Michelle Adler Morrison, CEO – Youth Guidance

OBJECTIVE: Ensure all students have access to high-quality, trauma-informed counseling, at every Chicago Public School as part of an integrated, culturally responsive model of care.

INITIATIVE: Ensure that every neighborhood school in under-resourced communities provides young women and men access to social and emotional counseling, in a school-based setting.

How deepening investments in social and emotional learning would advance the following values:
EQUITY | Communities that have historically lacked access to mental health services will have increased access to high-quality, evidence-based counseling, within a school-based setting.
TRANSPARENCY | The ready deployment of behavioral health resources will adequately reflect the shared decision-making process of school communities, in need of immediate, strength-based intervention.
ACCOUNTABILITY | Impact reports on student academic and social emotional outcomes will be shared publicly with school communities and neighborhoods.
DIVERSITY | School-based programs are culturally responsive and de-stigmatizing; built on a model of youth empowerment. More than 90% of Youth Guidance counselors reflect communities they serve.
TRANSFORMATION | When youth receive cognitive-behavioral therapy within a trusted group, youth are empowered to answer for themselves the central question of adolescence: 'Who am I becoming?' and the potential of youth is unleashed, to the benefit of entire communities.

WHAT IS HAPPENING TODAY THAT WE NEED TO KEEP?
CBO's like Youth Guidance are critical, providing culturally-responsive, trauma-informed and evidence-based supports that help students develop the necessary social emotional skills to succeed in school and life. Currently, our counseling programs span across 113 Chicagoland schools and are designed with a clinical foundation as in-school, strength-based interventions that support students, DCFS involved youth and young adults -- to build their social-emotional resiliency. Our counseling curricula utilize a Cognitive Behavior Therapy approach that encourages youth to reflect on how they make decisions. CBT focuses on the interrelation of thoughts, behaviors and feelings and has proven to be successful in treating a myriad of mental health issues, including depression, anxiety, aggression or PTSD.

Our two flagship programs Becoming A Man (BAM) and Working on Womanhood (WOW) each have two-year curricula with a lesson cadence that builds upon itself and works through our Core Values in sequence. BAM participants utilize the "Circle" of men during each session as a safe space to explore their feelings and practice vulnerability with one another. WOW draws upon Acceptance and Commitment Therapy (ACT) in its Circles, which uses acceptance and mindfulness strategies to increase girls' ability to deal with life stressors. ACT has been effective with anxiety disorders, depression and addiction. Girls are given the tools to help them decide what is important to them and then work through the challenge of making decisions based on their values.

BAM and WOW are delivered by our counselors, who build positive, transformative relationships that are key to our success in changing the life trajectories of the young people we serve. BAM counselors are college-educated youth development practitioners, who largely come from neighborhoods similar to those in which they work, preferably with extensive experience in psychology or social work. Similarly, WOW counselors are Masters' level social workers and counselors who undergo extensive training. Counselors work extensively to build trusting relationships with their students and are available to students outside of group sessions for individual counseling, case management, referrals, or other needs. As full-time staff embedded in CPS and integral members of the schools' support teams, counselors serve as a bridge between the classroom and a student's parent/guardian, facilitating communication and involvement that is rare in a typical urban school environment. A CPS principal recently shared how deeply counselors are embedded

into the school's ecosystem: "*when a BAM or WOW student is not doing well, the teacher's first option is to speak with the Youth Guidance counselor...it's clear that BAM and WOW have been a part of the comprehensive approach to behavioral supports for they serve as a targeted intervention for students, guiding them, using a very structured and proven process of counseling and mentoring*."

WOW has scaled by nearly 100% since last school year, serving 1,921 young women across 31 Chicago schools. The need for community-based mental health services like WOW persists. 1 in 3 children has experienced depression-like symptoms – a rate that is 25% higher among girls. Girls of color are at further risk for behavioral health issues due to compounded experiences of poverty, violence, and trauma.

WHAT DOES THE ADMINISTRATION NEED TO IMPLEMENT IN THE NEXT 100 DAYS?
Neighborhoods, including Humboldt Park, Englewood and West Englewood, are among seven zip codes across the City that have the highest amount of economic hardship and exposure to violence that also have the highest number of hospitalizations for mental health-related issues, including depression, anxiety, and substance abuse. Despite the urgent need for care in these communities, many lack access to trauma-informed treatment due to affordability, stigma and lack of healthcare. By maintaining a consistent presence in schools throughout the city, WOW not only works to fill this gap in services, but also to decrease the stigma surrounding mental health treatment among students in schools and help identify early-onset of symptoms. Under-served neighborhoods like Austin have seen declining enrollment and administrative transition. As part of our commitment to equity and closing the opportunity gap, Youth Guidance seeks public sector support and a sustainable commitment from the City that would enable schools across our highest need communities to receive priority funding, allowing evidence-models of CBT counseling to continue to serve youth in critical need.

WHAT CAN WE PLAN FOR THE LONGER-TERM IMPLEMENTATION?
Working towards equity in our city requires our city's citizens and institutions to recognize that socio-economic status & race remain indicators of the likelihood that someone will experience violence & traumatic events. Chicago remains within the top 10 cities with the highest homicide rates nationwide; where the leading cause of death for African American males, ages 15-24, is gun homicide; & where BYMOC are dropping out of school at disproportionately higher rates than their peers – 1 in 3 African American males drop out of high school annually & 20% of Latinx males dropped out of CPS in 2017. We live in a city where 1 in 3 children have experienced depression-like symptoms; where there is a correlation between the neighborhoods with the highest amount of economic hardship & exposure to violence & the highest number of hospitalizations for mental health-related issues.

With a unique combination CBT, men's rites of passage work, and a dynamic approach to youth development, BAM as a school-based program helps youth address maladaptive automatic behaviors, which the University of Chicago's Crime Lab finds are a key contributor to Chicago's violent crime. BAM has undergone multiple randomized control trials and evaluation has found that BAM reduces violent crime arrests for participants by 50% & reduces total arrests by 35% for participants as compared to their non-BAM peers. Research also showed BAM participants were 25% more engaged in school & 19% more likely to graduate high school on-time. Data indicates that societal benefits from BAM could be as high as $30 for each $1 invested.

WHAT CHALLENGES MIGHT THE ADMINISTRATION ENCOUNTER?
As the mentoring Initiative concludes its initial 3-years, over $1.75M in philanthropic commitments are sunsetting, creating significant need for increased public investment to maintain current service levels for our youth. Without sustainable funding from the public sector, the loss of programs like BAM and WOW will cause ripple effects within CPS school communities where BAM and WOW counselors have become woven into the culture of the school as essential supports. With a loss of funding, fewer boys and young men of color will receive mentoring, while young women will continue to be under-served.

Name: Dr. Arturo Carrillo, Ph.D., LCSW, MSW
Transition Committee: Health and Human Services
Prompt: Please pick one objective to focus your memo on from among the objectives that were shared with you on your invitation letter. To advance that objective, summarize in 2 pages:

· **A potential initiative (one sentence) -** Develop a city wide trauma treatment network

· **How the new administration can infuse the values of equity, transparency, accountability, diversity and inclusion, and transformation in this initiative**

There is a severe disparity in access to long-term, trauma-focused psychological care in the city of Chicago. The previous administration has exacerbated the problem with the closure of half the city mental health clinics in the first budget of his administration. Chicago's high economic hardship community areas have little to no access to professional counseling services, while Chicago's most affluent communities have an overabundance. For example, in the zip code 60602, which corresponds to affluent community areas in the center of the city, there is a ratio of over 324 private practice licensed mental health clinicians per 1,000 community residents. In contrast, in zip codes corresponding to high economic hardship community areas on Chicago's west, southwest, and south sides, there tends to be less than 0.1 licensed clinician per 1,000 residents.[1]Furthermore, the Collaborative for Community Wellness, a coalition of service providers, community-based organizations, and community residents focused on facilitating mental health service access to underserved community residents, conducted a systematic assessment of the accessibility of the 253 providers that the Chicago Department of Public Health identified, through a list that was released in the fall of 2018, as being sufficient to cover the needs of the city. Our findings point to concerns regarding the accessibility of the providers that the Chicago Department of Public Health has identified. For example, after making systematic attempts to contact each of the listed providers between December 28, 2018 and January 15, 2019, the Collaborative for Community Wellness was only able to connect with 59% of providers (150). We found that 11% of the providers (28) were inaccessible (phone was disconnected/not in service); 8% (20) were duplicate listings/providers; 18% (45) were difficult to reach (left at least two voice messages and couldn't make contact); and 4% (10) were not existent (e.g., agency or site had closed). Furthermore, we found that of the 115 providers who answered the question of whether their agency had a wait for mental health services, 34 (30%) reported having a wait list. Additionally, only 19 of the agencies with whom we made contact reported that they offered mental health services free of charge. We also assessed the accessibility of the Federally Qualified Health Centers (FQHC's) on the Chicago Department of Public Health's list, given that FQHC's are cited as an available resource for increasing access to mental health services in Chicago. It is important to note that 13% of the FQHC's that were contacted (4 out of 32) stated that they did not provide mental health services. Of the 28 FQHC's offering mental health services, 5 (18%) reported that they offer services free of charge; 4 (14%) had rates between $5-$15; 11 (40%) had rates between $20-$50; 4 (14%) had sliding scales but did not report their lowest rate; 3 (11%) did not offer sliding scale rates or

[1] Collaborative for Community Wellness (2018). Brief: Mental Health Provider Rate per Zip Code in the city of Chicago. Available at: https://www.collaborativeforcommunitywellness.org/

only accepted insurance; and 1 (4%) did not provide this information.[2] Taken together, these data point to serious concerns regarding the availability and accessibility of mental health services within the city of Chicago. It is also important to note that FQHC's as a model tend to offer short-term services focused on symptom reduction, and therefore cannot be viewed as a solution for facilitating access to long-term, trauma-focused services.

There needs to be a vision for transformation by the Lightfoot administration in a way that can provide access to long-term, trauma-focused care to residents within high economic hardship communities ravaged by generations of poverty and violence. As a mental health provider at Saint Anthony Hospital that offers free, high-quality, long-term, trauma-focused counseling services to Chicago's high economic hardship communities on the city's west and southwest sides, I can personally attest to the fact that organizational capacity cannot currently keep pace with the demand for services. Our mental health program at Saint Anthony Hospital has a year-long waiting list. Our program was around to respond to the wave of clients lost through the cracks when the Back of the Yards clinic closed in 2012. We rely on the remaining Lawndale clinic to provide psychiatric and psychological services while people are on our waiting list or require psychiatric evaluation.

A mixed methods mental health needs assessment conducted by the Collaborative for Community Wellness, which surveyed 2,859 residents on Chicago's southwest side, challenges the notions long held about the reluctance of Latinx residents to seek professional counseling services. Our findings indicate that survey respondents overwhelmingly identify structural barriers as posing the greatest impediments to mental health service access. Cost of services was the highest ranked barrier, with more than half of survey respondents (57%) identifying cost as posing a challenge to service access. Additional structural barriers included a lack of insurance coverage (38%) and a lack of services in close geographic proximity (34%). In contrast, social barriers were the lowest ranked among all the challenges that respondents reported. Of all survey respondents, 11% reported perceived stigma as an access barrier, while 10% reported that they did not believe services would help and 9% reported concerns about partner or family disapproval. Qualitative results from this assessment confirmed these survey data, and further highlighted the need for culturally responsive services in high economic hardship communities impacted by structural and programmatic access barriers.[3] A similar 3-year pilot study conducted on Chicago's west side indicated that among the 200 primarily African American (43%) and Latinx (30%) community residents who took part in the survey, the top three barriers to mental health service access were cost, transportation, and being unsure where to access services. Data across the southwest and west sides thus highlight the need to address structural and programmatic barriers in order to facilitate mental health service access within high economic hardship communities of color.

· And as it pertains to this initiative:

o What is happening today that we need to keep

It is of utmost importance that the city continues to invest in the five remaining Chicago Department of Public Health mental health clinics.

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[2] Collaborative for Community Wellness (2019). Assessing CDPH list of mental health providers. Available at: https://www.collaborativeforcommunitywellness.org/

[3] Collaborative for Community Wellness (2018). Uplifting voices to create new alternatives: Documenting the mental health crisis for adults on Chicago's southwest side. Chicago, IL: Saint Anthony Hospital - Center for Community Wellness.

o What we need to implement in the next 100 days
Executing Resolution R2018-1398: Call for creation of Public Mental Health Clinic Service Expansion Task Force to determine which community areas in need for re-opening of mental health clinics and identifying budgetary and operational recommendations for expansion of existing facilities and a third-party research entity to conduct study.

This resolution includes the need for immediate public hearings to better assess the mental health needs of Chicago residents.

o What we can plan for longer-term implementation
We can draw on models implemented in other metropolitan areas to inform the development of a Department of Emotional Wellness in the city of Chicago. Cities including Philadelphia, New York City, and the District of Columbia have Departments of Mental Health. Chicago can create a department that can interface with the Department of Family and Support Services, Chicago Public Schools, the Chicago Police Department, and other public serving departments of the city to create a comprehensive space for training, resource sharing, coordinated care, service provision, and crisis response.

o What challenges we might encounter in executing on this initiative
The city's traditional lack of investment in mental health services poses a challenge in executing this initiative. There needs to be sustainable financial investment in mental health services as a standard from the city budget. A budgetary analysis conducted by the Center for Popular Democracy of FY2017 identified that the Chicago Police Department had a total operating budget of $1.46 billion, compared to the Chicago Department of Public Health (which includes public mental health services) that had an operating budget of $32 million. As an additional comparison, the Department of Family and Support Services had an operating budget of $76.4 million.[4] Considering the disproportionate investment in the criminal justice system in comparison to the public health and social welfare system, a potential solution would be to reallocate funding from the Chicago Police Department to public mental health services in the city's operating budget. Establishing TIF reform is another possibility for increasing available funding for public mental health services.

[4] The Center for Popular Democracy, Law for Black Lives, and Black Youth Project 100 (2017). Freedom to thrive: Reimagining safety and security in our communities. Retrieved from https://populardemocracy.app.box.com/v/FreedomtoThrive

NAMI CHICAGO
Mental health advocacy, education and support.

04/15/2019

TO: Mayor-Elect Lori Lightfoot

FROM: Alexa James, Executive Director, NAMI Chicago

Dear Mayor-Elect Lightfoot:

The Mayor-Elect has a pivotal role to play in prioritizing mental health for all people who live and work in Chicago. And now is the time to make a commitment to bettering our city and healing our community. It starts with strong leadership establishing an open dialogue with providers, patients and people setting clear roles and expectations of the players in our mental health system and being transparent around mental health funding. And it requires the city to play its best role: coordinator and funder of services.

I would like to highlight a few recommendations from NAMI Chicago's Roadmap to Wellness,[1] which is a guide for city leadership to begin building a comprehensive mental health system in the City of Chicago. Through the below recommendations, the Mayor-Elect can lay the groundwork for this huge undertaking and infuse our shared values of equity, transparency, accountability, diversity and inclusion, and transformation.

Invest in data integration for city case management services.
Many individuals and families in Chicago touch multiple systems of treatment and support, however these systems are not currently able to communicate with one another. It is often difficult to assess needs without a full picture of programs individuals may be eligible for or are already engaged in. Transforming the use of data across city agencies promotes transparency among city services by beginning to break down silos between programs that are there to benefit our community. Integrated data sharing among city agencies would promote effective use of resources and allow for streamlined case management. Buy-in across city agencies, particularly frontline staff, is crucial to the success of an integrated data sharing platform. If implemented, ongoing training and support must be provided to frontline staff to encourage utilization of such a platform.

Fill gaps in the mental health workforce.
There is a very real psychiatrist shortage in Illinois and throughout the country. We must maximize the entire mental health professional field to meet the city's growing needs. One of the challenges in the use of telehealth is that technology can be expensive and development of telehealth platforms are often not reimbursable. In many high need areas of Chicago, we see inequitable access to mental health services, and the ability for providers to offer expanded services through telehealth can begin to alleviate these disparities. While the city does not control reimbursement for telehealth, it can invest in technology that supports providers using tele-psychiatry and provide start-up funding to help expand its use in Chicago.

[1] NAMI Chicago's *Roadmap to Wellness* is available at: https://namichicago.org/wp-content/uploads/2019/01/NAMI_roadmap_FINAL-012319.pdf

Develop and fund crisis response teams.
Coordinated planning is needed for response to traumatic events that impact students across the city. Using a crisis planning process, certified annually by the Chicago Public Schools (CPS), each school in the district could identify on-the-ground supports that can mobilize quickly after a traumatic event. Specifically, a team of teachers, staff and administrators within a school form designated crisis teams. These teams can be trained in psychological first aid and can assist with intervention and post-vention protocol that will support the entire community. Additionally, these teams should be flexible enough to address issues before they become a crisis—such as changes in school or community environment that might be impacting student mental health.

Expand opportunities for older adults to age in place.
The ability to live in one's home throughout the aging process provides the opportunity for stability in the community and contributes to independence, all impacting mental wellness. But there are a number of factors that impact whether an older adult can age in place, such as home modifications, assistance with personal care, maintenance of the home, transportation, and money management. Making aging in place attainable for older adults, with necessary supports that allow for independence, can positively contribute to ongoing mental and physical health.[2] The City of Chicago's Department of Family and Support Services (DFSS) Senior Services program provides a range of services that allow older adults to remain independent. The city must continue and expand investment in these services as a specific strategy to addressing the mental wellness of older adults.

We need your help to move the system forward. To meet changing needs, the mental health system needs central coordination. With your leadership and the support of the mental health community we can reduce stigma and fully integrate mental health and wellness into the daily lives of all Chicagoans at every stage in life.

Sincerely,

Alexa James
Executive Director
NAMI Chicago

[2] U.S. Department of Housing and Urban Development. 2013. "Measuring the Costs and Savings of Aging in Place." Accessed April 15, 2019. https://www.huduser.gov/portal/periodicals/em/fall13/highlight2.html

NAMI CHICAGO
Mental health advocacy, education and support.

To: Mayor-Elect Lori Lightfoot

From: NAMI Chicago; HHS Committee

Chicago has aimed to be a trauma-informed city. Through investment in training, coalition building, and strong private-public partnerships, we have shown dedication to this goal. We are asking city employees, particularly first responders, and Chicago Public School teachers and administrators to engage in this practice so that the residents of Chicago are experienced and served through a trauma-informed lens. However, we have not provided consistent support and resources to the public workforce that is needed for them to thrive and deliver on these goals.

Initiative 1):
Create a strategy for the public workforce to increase their mental and emotional wellness.

Initiative 2):
Create an officer of Health Equity / Community Wellness.

The city is paying attention to the risk of trauma by Chicago's first responders and conversations are being had. Currently, the Chicago Police Department has organized a small task force to look at these issues.

Although more bandwidth needs to be added to all Employee Assistance Program (EAP) in the City of Chicago, that is one piece of a larger reform that needs to take place.

Currently, the Chicago Fire Department (CFD) has two clinicians in their EAP program. This is housed in the CFD training academy which may be a deterrent to people actively seeking support as it is not seen as completely confidential.

The Chicago Police Department is planning on hiring more clinicians and now has 7.

It is unclear if all other departments use the one clinician in the City's EAP.

100 days:

- Immediately providing a wellness and satisfaction survey to all city employees
- Include their feedback continuously in creating a toolkit for each city agency and maybe each department to utilize to promote mental wellness for their employees. This includes all city employees.
- Audit current city insurance to ensure mental health parity
- Audit current mental health providers in the insurance network and their waitlists

- Ensure all supervisors have training on signs and symptoms of mental health issues, compassion fatigue and how to most appropriate have discussions with staff about this and how to make referrals. *This training is currently being planned for Q4 for the CPD supervisors per the Consent Decree.*

- Create peer support using best practices – maintaining the same peer during and throughout intervention and post- vention unless rejected by the party desiring peer support.
- Integrate into the wellness tool kit should be traumatic incident reports that create clear guidelines and timelines to supporting someone post a stressful or traumatic event. For CPD – review current policy and make adjustments that include all city employees involved in the incident including OEMC, other officers, and command staff.
- Contract with an outside provider with expertise to provide 6 free therapy sessions a year with the option for more
- Examine legislation, contracts that reduce the likelihood that those desiring mental health support seek it out.

Long Term Implementation:

- These plans and toolkits will be certified and approved by the new office of Health Equity
- During orientation/recruit training include family and help employees identify their support systems. Ensure families understand the work of their loved ones (specifically applicable to first responders and teachers) Continue to engage families and when appropriate remind them they too have access to Professional Counseling Services (CPD specific)
- Provide ongoing training by subject matter experts on the impact of chronic stress and trauma on the brain.
- Training from recruit level on emotional intelligence, risk, and awareness of PTSD, Compassion fatigue, secondary trauma, along with general changes they may see through the job
- A daily allowance of 30 minutes for exercise/meditation or wellness activity every shift
- Integrate story sharing by peers about their experience using mental health support in all conversations about mental health
- Provide offer wellness related workshops and seminars accessible to all in all communities at all times that work for those working non-traditional hours
- Ensure leadership creates a culture of safety in asking for support
- Change sick days to wellness days.
- Create a strong network of providers in the insurance network that the City trains and invites in to acculturate to the culture of the various disciplines and departments
- Train primary care doctors to better identify mental health related systems related to trauma

Anticipated Challenges:

- The expense of integrating ongoing wellness support although ultimately a health workforce shows great costs savings.

- The number of employees in the organization, and the current workplace culture that prioritizes operations over employee wellness.

- The stigma associated with mental health treatment seeking
- Lack of resources
- Limitations of insurance
- Factors that exacerbate mental health concerns: canceled days off, working overtime or side jobs and missing sleep, financial stressors, family stressors, poor morale, lack of adequate supervision and clear job expectations.
- Paradigm shift

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TO: Mayor-Elect Lori Lightfoot

FROM: Bela Moté, Chief Executive Officer, Carole Robertson Center for Learning

DATE: April 15, 2019

Thank you for the honor and opportunity to share my thoughts and ideas on key steps your administration must take to build resilient communities across the city through your Health and Human Services transition committee. Given your campaign's stated values of equity, transparency, accountability, diversity and inclusion, and transformation, it is critical that the voices of child- and family-serving community-based organizations like the Carole Robertson Center for Learning substantively drive conversations and policies. I commend you for assembling diverse and inclusive transition committees to take on this important work.

The Carole Robertson Center for Learning has a 43-year history of serving children, youth, and families on Chicago's West Side. We were founded in 1976 as an after-school program for youth whose alternative high school was closing its doors. The founding youth, parents, and leadership named the program after Carole Robertson, one of the four girls killed in the 1963 Birmingham church bombing, to represent their commitment to social justice and equity in access to a high-quality education. Over the following decades, we have weaved a fabric of trust with the families we serve who, generation after generation, choose to return to us to empower the education, health, and mental well-being of their children from the prenatal stages of life to age 18.

The communities and families we serve face trauma from community violence and other stressors of poverty, and we have learned hard-earned lessons in partnership with them on how to build healthy, resilient communities within the context of both intervention and post-emergency supports when trauma occurs. From this experience, I suggest that your administration consider a dual-track approach to structure this work.

The first track of this framework demands rigorous, family- and community-driven thinking on practices and environments within communities that face significant trauma. From the perspective of the populations the Carole Robertson Center works with, for instance, this means implementing research-based social-emotional learning practices in the classroom and embedding natural hooks for evaluation with validated and developmentally appropriate tools. Equally critical is our partnership with families, the first and foremost experts on their children, to use these tools in the service of data-driven, co-creative decision-making and individualized classroom practice. These practices must occur in environments and spaces that are not only physically safe, but emotionally safe as well. Investments in such spaces, in tandem with the right practices in those spaces, bring outsized returns to the community.

The second track is to take a more expansive view of what it means to meet the needs of our community from an equity lens. We have found how critical it is to acknowledge that the workforce of individuals in the health and human services sector in Chicago is largely comprised of community members that face the same kinds of trauma experienced by the people they serve. I

remember being particularly struck during a conversation with a teacher who, several minutes into a discussion about behavioral issues exhibited by a child in her classroom, cursorily mentioned that the child was a witness to gun violence that took the life of his father. Such reactions from our workforce demonstrate how insidiously trauma is normalized in our communities. If it is the case that the people who work with our children and families live in the same communities and experience similar kinds of trauma, it is critical to be equally thoughtful in constructing a trauma-informed approach to building the social-emotional capacity, competencies, and practices of the health and human services workforce in Chicago.

If these are the two key foundations upon which to build resilient communities under your administration, there are some key short-term and long-term goals that follow. The first is to maintain the current robust ecosystem of public-private partnerships in the service of community resiliency and the health and human services sector writ large. While not exclusively a Chicago-based partnership, the Illinois Children's Mental Health Partnership comes to mind as a model example of how children, families, public agencies, research institutions, community-based organizations, funders, policymakers, and advocates can partner together, learn from each other, and contribute their unique skillsets and toolkits in the service of rigorous mental health practice in the state. The Carole Robertson Center is a partner in its mental health consultation program, and believes strongly in the importance of elevating the voices and perspectives of families and community-based organizations in this work.

In the immediate short term, the city must additionally develop a deep appreciation of how the health and human services workforce has a set of risk factors and triggers that need to be addressed in an asset-based way. As I shared in my story before, our staff often do not acknowledge that they are themselves traumatized. The Carole Robertson Center has approached this work through the creation of a mental health framework informed and implemented by staff throughout our organization, centered on cultivating staff practices. Through this process, we also generate buy-in and excitement for the rigorous practices and safe environments that comprise the first component of the dual-track approach.

In a similar vein, a goal for long-term implementation is the development and distribution of resources to professionalize the workforce and provide cross-sector professional development opportunities for embedding trauma-informed and resiliency practices. This must happen hand-in-hand with the scaling of effective models and solutions. It is critical to leverage economies of scale when possible, while still acknowledging and making space for unique, community-specific solutions.

Indeed, I want to emphasize that the action items listed above must be driven by family and community voices and conversations. It is important for community-based organizations and other experts to share practices that work, but equally if not more important is the elevation of the perspectives and experiences of community members and families. Trauma manifests itself in ways too numerous to count, and particularly so in impoverished communities. Only those directly experiencing that trauma can truly represent the issues they face, and they should be in the driver's seat when creating solutions for their communities.

Thank you again for this opportunity to share my thoughts. I look forward to further engagement on these key steps for your administration as it embarks on the important work of building resilient communities.

Memo

To: **Mayor-Elect Lori Lightfoot**

From: **Christine Achre**
Member, Health and Human Services Committee

Date: **April 15, 2019**

Objective #2: Ensure all Chicagoans have access to integrated health services, especially where data shows gaps exist

Summary:
There has been excellent data collected to date (i.e. Healthy Chicago 2.0; Chicago Atlas). These reports have collected excellent neighborhood data inclusive of all of the communities in Chicago. In addition to neighborhood data, it is important to expand the definition of "community" to also include population health. One such community that doesn't always identify with a particular neighborhood are the homeless.

On behalf of my work at the Primo Center, I would like to share my experience with Kids Connected, a new collaborative funded by the Illinois Children's Health Foundation, that, in my personal opinion, embodies the four important values that Mayor-Elect Lori Lightfoot has embraced for our city.

"Kids Connected" is a new program that ensures integrated care for homeless families in Chicago by creating a system of care that fully coordinates all aspects of their care--physical (including asthma, pre-diabetic and diabetes, poor nutrition and lead poisoning education) and behavioral care (including trauma-informed care for families, MAT and other substance use services, education support, and housing—resulting in improved health outcomes, education stability and the end of their homelessness, for good.

What is Happening Today:
Kids Connected is a collaboration of three lead human service agencies—Heartland Alliance Health, Catholic Charities of the Archdiocese of Chicago and the Primo Center—plus a community planning team led by representatives of every child-serving system in the city and state, including DCFS, DFSS, IDJJ, SUPR, CPS, and the Governor's Office of Early Childhood Development, families with lived experience, multiple service providers, philanthropists and thought leaders.

What We Need to Implement in the Next 100 Days
Starting in June 2019, skilled assessors will go into Chicago's shelters and use standardized assessments to measure needs. The roll out of the care coordination starts with families in August 2019. Messaging from the Mayor about the importance of

this collaboration and the need for intra-agency coordination will strengthen the mandate to get this done.

Planning for Longer-Term Implementation
Kids Connected uses care coordinators to manage all aspects of homeless families' care. In year 1 of implementation, 50 families will be served, and by the end of 5 years, the system will care for 500 homeless families. This model can end homelessness for every homeless family in Chicago.

Challenges to Be Encountered
Coordinating multiple systems with competing visions and even different languages for care is a challenge. Finding routes to braid resources despite regulatory barriers is a second challenge. Sustaining the funding for housing and services will require the adoption of this model by managed care organizations and the creation of housing for homeless families, as envisioned in *Bring Chicago Home*.

Infusing the values of equity, transparency, accountability, diversity and inclusion, and transformation into Kids Connected:

Equity: Homeless families are transient and are not tied to specific geographic communities. Kids Connected expands the concept of "community" to encompass the needs of an entire population and finally address their specific needs.

Transparency and Accountability: This type of massive systems coordination requires transparency in intention and action in order for this collaboration to work. The size and depth of the community planning team will ensure transparency and accountability, as members report on their activities and hold each other accountable for making the necessary systems change.

Diversity and Inclusion: Central to Kids Connected is the leadership of families with lived experience, who have been consistently excluded from system planning. This leadership will ensure that the system of care is developed *alongside* them, not just *for* them.

Transformation: The work of Kids Connected is to radically transform how homelessness is addressed for homeless families, using care coordination that follows them and adjust as their needs change, and that truly addresses the totality of circumstances that causes their homelessness, thereby finally ending it.

FROM: Dr. Colleen Cicchetti, Ph.D.
Executive Director, Center for Childhood Resilience (CCR)
Department of Child and Adolescent Psychiatry
Ann & Robert H. Lurie Children's Hospital of Chicago
Associate Professor, Feinberg School of Medicine, Northwestern University

TO: Health and Human Services Transition Committee

I am pleased to submit an idea in support of the objective: *Ensure all Chicagoans have access to integrated health services, especially where data shows gaps exist.* In particular, I believe that access to coordinated/ integrated health services is particularly critical for children. I therefore propose that Mayor-Elect Lightfoot **build upon existing programs that promote a public health approach to children's health that recognizes the negative impact of exposure to trauma, poverty and violence while also investing in workforce development and training of all child-serving sectors to promote wellness for children, families and communities.**

Values

Lurie Children's shares Mayor-Elect Lightfoot's values, and they have been infused throughout our work to improve the health of Chicago's children. **Transparency** and **accountability** are ensured through our research and evaluation; we are undertaking ever broadening efforts to improve the **diversity and inclusion** of our workforce, including creating pipelines for youth of color to pursue health care careers. Through our Healthy Communities initiative, we are pursuing **transformative** program-based, clinically-informed strategies to ensure health **equity** for children and families in communities experiencing concentrated disadvantage. One example of our commitment to these core values lies in our collaboration with CDPH in the *Voices of Child Health in Chicago* program (selected *Reports* attached; https://www.luriechildrens.org/voices),which reflect data collected from more than 3300 Chicago households (including more than 1,000 Chicago parents/guardians) from all 77 community areas in Chicago. By polling the public for its perspectives, we ensure that community views (including substantial concerns about behavioral health) are part of our city's conversation about child health. We hope to continue this vital partnership with your administration.

Healthy Chicago 2.0 established a goal of making Chicago a "Trauma-Informed City." As noted in the policy brief, "Prioritizing the Health of All Chicagoans," children who experience the highest rates of exposure to trauma, poverty and violence are also the children least likely to access consistent healthcare in a "medical home" in which prevention, early identification and sustainable treatment plans are the priority. To address this inequity and nurture healthier citizens, we must invest in innovative strategies to shift the narrative in our city to one in which citizens from every community understand that the health and wellness of every citizen is critical for the viability and growth of our city. Therefore, every individual must "step up and step in" to share their individual assets (financial, professional and time) to ensure success.

What is happening today that we need to keep

Healthy Chicago 2.0 provides a useful framework for promoting an equitable, public health approach. In particular, the Chicago Health Atlas, provides an extraordinarily useful tool for addressing Mayor-Elect Lightfoot's values of **transparency** and **accountability.** The data collected and made accessible via the Chicago Health Atlas provide essential assessments of the health and risk factors in all Chicago neighborhoods, as well as a tool for tracking progress in meeting various health objectives relating to health initiatives across the city. Promoting public awareness through the Health Atlas allow facilitates increased dialogue and strategizing to address the lack of **equity** across communities.

Chicago Public Schools have begun a series of initiatives to promote the awareness of trauma and to build a more comprehensive approach to the education of students. In many networks, these efforts have progressed beyond simple awareness to building specific practices, investing in structures and systems to identify students experiencing distress and linking them to evidence-based interventions within their school or community. Despite significant growth in understanding of the necessary supports required to promote social-emotional functioning for our students, most of these innovative approaches do not have a sustainable source of support. Grant programs with funding from state, federal and philanthropic dollars are typically short lived and are not able to provide sustainable services.

The city of Chicago must invest in providing school-based services through advocacy to obtain adequate funding and coordinated workforce development efforts to insure that our behavioral health expert ratios meet national best standards (for school counselors, social workers and psychologists). Training non-mental health clinicians in a public health approach to mental health and wellness is another critical component for pursuing **transformative** change. This includes training teachers, first responders, early childhood educators, and faith-based and recreational providers (for example Girl Scouts, Boys & Girls Clubs, Park District) to recognize both the potential negative impact of exposure to trauma, as well as the signs and symptoms of distress and mental health disorders. This work needs to be supported with access to pre-service training and ongoing professional development. A coordinated effort to require this training for all city agencies and vendor organizations is a necessary next step. In addition, continued investment in efforts to operationalize the basic information and skills that would be required to meet a minimum standard of both trauma awareness and trauma responsive practices is critical. CCR is currently working with a collaborative stakeholder group to build a Trauma Sensitive Schools Designation for the State of Illinois. This type of model provides common assessment tools, action planning processes and investment in professional development as well as tools for policy makers and the public to ensure **accountability, equity** and **transparency**.

Youth voice is increasingly recognized as critical to identifying **transformative** solutions to complex problems. This is true when addressing health disparities and stigma surrounding mental health. CCR and CDPH have worked with Mikva's Health Council to construct a pilot Mental Health Ambassador program. The young leaders have developed tools and presented information designed to decrease stigma and educate peers about trauma and mental health concerns from an **equity** perspective. I would encourage the Mayor-Elect to continue to engage young leaders to learn about their innovative strategies and solutions, and to build a model for further youth engagement in public health solutions.

What we need to implement in the next 100 days

- Expand investment in the Healthy Chicago 2.0 goal of building a robust Trauma Informed City
- Identify emerging models for supporting primary care settings to provide coordinated care and address mental health needs for students and families. This includes telemedicine partnerships with SBHC's and primary care partnerships.

What we can plan for longer-term implementation

- Explore models for Medicaid expenditures that would support expanded medical and mental health services to be delivered in schools. Investigate models from other cities and states that extend coverage for more prevention and early intervention services.
- Invest in coordinated care efforts in communities most impacted by poverty and violence that provide a full continuum of care from prevention to crisis and long-term supports for children and families. Support collaborations between these community leaders and academic partners to identify key success factors to build replicable and culturally relevant models for our diverse city.
- Encourage pre-service training cooperatives that enable health profession programs, schools of education, and city colleges to build a robust coordinated health and human services workforce, including pathways for training of community health navigators to support community awareness and access to health resources.
- Convene pediatric academic institutions including medical schools to direct them to engage in a more coordinated effort to build a workforce of pediatric health care providers that are equipped to address both health and mental health needs of their patients and families, with emphasis on disadvantaged communities.

What challenges we might encounter in executing this initiative

The models and expertise to advance a public health approach exist in Chicago. Many public and private organizations work tirelessly to promote awareness and build culturally appropriate strategies and interventions. The City must align significant and consistent resources toward this key priority, through commitment to expenditures and investments in multiple domains that may not produce immediate results but will ultimately benefit the health and wellbeing of our city. This type of forward-thinking leadership, coupled with ongoing public engagement toward shared goals is required. Lurie Children's and the Center for Childhood Resilience stand ready to collaborate in this critical effort.

I AM ABLE Center for Family Development, Inc.

A Trauma Informed Care Agency
"Empowering Families, Strengthening Communities"

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MEMO Health and Human Services Committee

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TO: Mayor-Elect Lori Lightfoot
FROM: Carolyn L. Vessel, MSHSA, M-Div., DD
PROMPT: Help build resilient communities by establishing a protocol across the city for responding to acute trauma, including immediate intervention and post-emergency support

The new administration can infuse the values of equity, transparency, accountability, diversity, inclusion, and transformation into this initiative by taking a deep dive into the inequity that exists when the word resilient is used in communities of color, especially the African American Community. This is a dangerous word for African Americans because of the Intergenerational trauma and systemic racism that exists in our nation, and our city. This is demonstrated by the violence perpetrated and allowed by those who are employed with our tax dollars, who are resilient because they have access to healthy living and safety choices, as well as the best of services, schools, etc., while the majority have little or no access to anything of quality as it relates to health and human services, and customer care. This increases Post Traumatic Stress and Captivity Disorders (PTSD & PTCD).

I am pleased by the term help build, because resilient communities do not exist for the masses, because of the senseless ongoing trauma, and PTSD/PTCD suffered by African Americans. This is due to the myriad of repetitive, systemic violence's perpetrated on our families, which causes African American families to hang on by a resilience thread. For so many, there is no thread left to hang on to. The result is fatal, as we stressfully exist, or die!

Those in our city for whom resilience works, make a livable wage, are not systematically left out of that which promotes high quality living and they pay fewer taxes. They grow up in families that are accustomed to and don't have to fight for quality institutions, stores, public servants or the service industry. Employment and entrepreneurial opportunities are the norm. Meanwhile, staggering numbers of African Americans face unemployment, jail, food deserts, low performing schools in dilapidated, lead, and rodent infested conditions. These issues, as well as homelessness, hopelessness and helplessness are the factors that guide the resiliency code of those at-and below the poverty level, who are unable to make and maintain a livable wage, especially after being taxed to death, with the highest property tax system in the nation, designed to hurt the poor in our City, and County. Bringing home 60-70 cents on the dollar is criminal when you have minimal income. When African American families, that continue to work at recovering from 400 years of Captivity, are systematically undermined by present day systems that push resiliency and recovery without restoration of that which builds African American's capacity for success, resiliency is almost as bad as lynching, The life is choked out of

African American families via overt captivity of the past, with no reparations, and covert modern day captivity, that is resurging by ignoring the obvious and placing every other issue, before this unresolved sin, and so-ugly on the face of America!

If Chicago, is going to be the City that works on this high calling of building a resilient city, it must become the model city for destroying racist practices and employing restorative justice for African Americans first. This administration must introduce the PREVENTION strategies from before birth to address morbidity and mortality issues, to quality living to ensure that resiliency can be re-introduced to African Americans. We must have equal footing. This will be evidenced when Chicago intentionally alleviates and dismantles the warped ecosystem which denies that African-American lives matter. Chicago can then attempt to promote resiliency, once the playing field is leveled and we can all begin to run and thrive together.

You only want to be resilient when you are in a good place, a healthy place and a place according to definition, that equips persons with the power and or ability to return to the original form, or position, after being bent, compressed, or stretched. That's the challenge before us Chicago. When the elasticity has been taken out of a people, they cannot be resilient, it requires a new piece of elastic. Otherwise, the people only exist, and cannot avoid trauma, recover from trauma, or be expected to spring back to life from trauma. They must become trauma informed, and those who have closed their eyes must see and operate through a Trauma Informed Care (TIC) lens.

Pre-911 supports, must be intentionally put in place to end the poverty, poor education, incarceration and harm done to the people who built this country. If any other issue is to be worth the time, effort and dollars that will be applied so others can be resilient, African Americans must become the priority in our city. African Americans continue to face the devastation and lingering damage done to our lives, because while others are advancing, 'we always have to fight ' for what is so naturally given to and expected by other people groups. This is evidenced by the conditions of the schools, streets, stores, customer care, and racist practices in nearly every institution in our city, especially the government. We need new elasticity, due to the intentional lack of quality (TIC) in our communities.

And as it pertains to this initiative:

o What is happening today that we need to keep working until a real solution is developed: One that allows African Americans to be on a level playing field so they can be resilient.
o What we need to implement in the next 100 days: A replicable plan that will focus wholeheartedly on the New Elasticity that will be intentionally put into the lives of African Americans, making Chicago the Model City for Resilience in Health and Human Services
o What we can plan for longer-term implementation, Block-by-Block Campaigns in every blighted African American Community, that restores the elasticity for resilience. Violence, poor health, and failed human services must become a thing of the past, so a high quality of life and life expectancy for African Americans become the new Chicago data set.
o What challenges we might encounter in executing on this initiative. The voices of those that hate African Americans, and continue to perpetuate racist practices, while putting every other issue, before this ongoing, age old issue of hatred against this people group.

Issue: A Public Health Approach to Violence Prevention Is Not Simple About Treatment and Services. Rather, It Must Also Prevent People From Developing Unhealthy Criminal Histories While They Are Receiving Treatment and Services. Therefore, the City of Chicago Should Pilot the Use of Non-Monetary Civil Citations Instead of Arrests for Misdemeanor Offenses.

For people who encounter the criminal justice system, the impact of an arrest, let alone a conviction, can be significant. Justice involvement can create challenges engaging in school, getting a job, securing housing, and can negatively impact family relationships. These are the realities for people who interact with the justice system, whether it is a result of untreated mental health conditions, or other reasons.

In states like Florida and Delaware, the introduction of non-monetary civil citations in lieu of an arrest has shown great benefits. These states have formalized processes for law enforcement to provide a civil citation, avoid arrests for non-serious misdemeanor offenses, and connect people to services through an assessment center model or otherwise. Particularly in Florida, with significant emphasis on transparency and reporting, the effectiveness of this type of program is clear.

Florida's civil citation program is authorized by Florida State Statute 985.12, which provides law enforcement with an alternative to arrest for people who commit first-time, non-serious criminal acts.[1] In addition to the eligibility criteria, legislative requirements of the civil citation program include statewide implementation at the local level, assessment of needs, and reporting for tracking and analysis. This shift occurred to keep people who pose no real threats to public safety out of the justice system with no arrest record established, reduce costs of processing people for misdemeanors, and free up limited resources for law enforcement to focus on more serious and violent offenders. As of July 2017, 61 of Florida's 67 counties had an active civil citation program.[2]

A review of Florida's program shows that people who received a civil citation recidivate less than eligible people who were arrested and diverted,[3]and overall, just 5% of those who received a civil citation recidivate, which is the lowest recidivism rate of programs tracked.[4]

Delaware also utilizes a statewide model of civil citations. The program is an alternative to a formal arrest and criminal prosecution for certain low-level misdemeanor offenses.

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[1] Pla, J., (2014). *Briefing Report: Civil Citation Effectiveness Review.* Tallahassee, FL: Florida Department of Juvenile Justice. Accessed, 1/8/2018: http://www.djj.state.fl.us/docs/research2/briefing-report-cc-(8-6-14).pdf?sfvrsn=0

[2] Florida Department of Juvenile Justice, (2017). "Florida Civil Citation." Accessed, 1/8/2018: http://www.djj.state.fl.us/partners/our-approach/florida-civil-citation.

[3] Pla, J., (2014).

[4] Roberts, T., (2015). *Civil Citation.* Tallahassee, FL: Florida Department of Juvenile Justice. Accessed, 1/8/2018: *http*://www.djj.state.fl.us/docs/car-reports/(2014-15-car)-civil-citation-(12-21-2015)-mg-final.pdf?sfvrsn=2

Next Step

Chicago should pilot a program, such as the use of non-monetary civil citations, that avoids the use of arrest for misdemeanor offenses committed by people living with mental health conditions. In Florida, the civil citation utilizes community based services already available through their Department of Support Services and investment by the state. The civil citation in Delaware is funded by the US Bureau of Justice Assistance, as well as by the state.

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TO: Mayor-Elect Lori Lightfoot

FROM: David Ansell, MD, MPH
Senior Vice President, Community Health Equity

RE: **Chicago Department of Public Health and the health and well-being of Chicagoans**

Any approach to the health and well-being of Chicagoans should consider the following. First, neighborhood structural conditions- poverty, racism, housing quality, joblessness, food access, poor educational outcomes, violence, all contribute to poor community health outcomes. Health is inherently intersectional and the economic vitality of a neighborhood, the neighborhood built environment, educational achievement and the access to health care are interconnected determinants of health. Of these social determinants, economic vitality and educational achievement are the most critical predictors of good health. The community areas in Chicago with the worst health outcomes, are high hardship areas and have seen the greatest drop in relative income since 1970 compared to the rest of the city. While it is important to set health condition specific priorities in high hardship neighborhoods, it's also necessary to understand that a disease by disease approach has limitations in the absence of economic and educational initiatives that address underlying economic conditions. So we recommend that the health and human services initiatives the Mayor chooses should be contextualized under a broader umbrella that acknowledges this intersectionality.

Second, it is necessary to understand the history of prior health initiatives and understand why some of them have failed. Often times, these initiatives have been either poorly executed, were not equitable and inclusive of critical partners, not community centric, not scalable or not sustainable. Yet, there are also examples of very successful initiatives that have made a difference in the health of Chicagoans-

HIV/AIDS initiatives and the work of the Metropolitan Chicago Breast Cancer Taskforce as examples. These have been broad based with multiple partners, cross sector, with community partners, and strict outcome measurement. Third, any new initiative should build upon work that has been organized under the framework of Healthy Chicago 2.0 and other community engaged initiatives (such as West Side United.) Lastly, the Chicago public health infrastructure has been critically underfunded and has difficulty effecting change. Health in the city has also suffered because of the fragmentation of city departments beyond CDPH. The Department of Family Services, Chicago Public Schools, and CDPH have often worked independently to the detriment of health of the citizens.

What should be implemented in next 100 days:

- Develop a framework to have equity and inclusion a core value in all city policies and city departments, including CDPH
- Frame a long term (30 year) holistic vision to improve Chicago including the health and well-being of all Chicagoans through a multisector approach
- Develop alignment, including community feedback regarding proposed health initiatives
- Set meaningful, ambitious, specific and time limited outcome measures for initiatives
- Implement the CDPH postnatal home visit program (Maternal and Infant Mortality)
- Align and integrate CDPH initiatives with West Side United and other community specific health and well-being initiatives.
- Address critical funding gaps that keep CDPH from being an change effector

Longer term challenge: There are three overarching challenges: 1) Mistrust of city government 2) Funding of initiatives and 3) Inability to execute

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To: Mayor-elect Lightfoot

From: Dan Fulwiler, President and CEO, Esperanza Health Centers

Date: April 14, 2019

Objective: Ensure All Chicagoan's Have Access to Comprehensive Health Services

Proposed Initiative: Bolster the existing network of care for underserved residents of Chicago, including Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs).

What is Working

- The City is well served by FQHCs providing accessible, integrated care for the underserved. These health centers are governed by community members (51% of their board members must be patients according to statute) and are highly responsive to community needs. According to HRSA, there are more than 140 FQHC service sites in Chicago, serving more than 640,000 individuals, a 20% increase in the last five years alone.
- All the FQHCs in Chicago provide behavioral health services, and most provide MAT services for substance abuse.
- Though financially stressed, Chicago's Community Mental Health Centers also provide services to many of the underserved facing behavioral health problems. This network should be supported.
- The Chicago Department of Public Health is one of the strongest in the country. Their focus on the core public health functions assessment, policy development, and assurance ensures that we reduce the risk of major health epidemics in the City and supports the private, nonprofit and public health infrastructure in the provision of care.

What Needs Immediate Attention

- Create a grant program to support the initiation or expansion of mental health services in Chicago's most underserved communities by FQHCs and CMHCs. A grant program of $10 million per year could have a huge impact in the neediest communities. Funds should be given as seed grants to get programs off the ground, and should taper in amount over three to five years, with each project having to seek sustainability funding from other resources including State and Federal grants and fee-for-service.
- The City should work with the State to ensure that the problems encountered in the Medicaid redetermination process over the past year are fixed quickly. About 10% of all Medicaid recipients in Illinois have lost their coverage in the past year due to administrative changes. This

loss in coverage has a profound effect on underserved Chicagoan's lives and on the financial health of the organizations that serve them.

- The City should advocate with the State for higher Medicaid rates for specialty care and behavioral health services. Illinois offers some of the lowest Medicaid rates in the country. While primary care needs can be filled by FQHCs and hospital services are adequate, the middle level of care including specialists for both physical and behavioral health are grossly inadequate. Better payment rates would ensure the stability of these networks.

What Must Be Addressed in the Longer Term

- We are in an age of information connectivity and it is changing industries across the globe. Health care has been slow to keep up. The City should work with other public entities to promote the uptake of medical record connectivity to ensure that care is integrated across the spectrum from primary care, to specialist services to inpatient and post-acute care. Without sufficient connectivity, we will never be able to truly integrate care. The City should support efforts to improve HIEs and other forms of data exchange as well as next generation payment models like ACOs. There are local organizations with deep expertise in these areas, including Matter and the Medical Home Network. The City should tap these sources for expertise and work to create a globally recognized system of care for the underserved.

- The City should consider creating a system of health coverage for the uninsured and/or work with Cook County to create such a system. There are models that work from as close as DuPage County to further afield in Orange County California and elsewhere. Chicago has some of the finest health care in the world. It should be available to all residents, and committing to care for the uninsured should be a priority.

How This Initiative Supports the Values of Equity, Transparency, Diversity and Inclusion, and Transformation

The system of healthcare in America is inherently unequal. Continuing to bolster the primary care safety net through supporting FQHCs and CMHCs will make it more equitable.

FQHCs have some of the most diverse boards of any non-profits because they are required to have at least 51% patient members who represent their communities. FQHCs also hire large numbers of staff from the communities they serve.

FQHCs and CMHCs are natural innovators. They are constantly creating new programs to respond to community needs.

Health and Human Services Transition Committee

Ensure all Chicagoans have access to comprehensive care

The incoming administration should put Chicago on a path to guarantee access to vital and comprehensive healthcare services for all Chicagoans. This audacious objective is attainable through City Hall leadership, intergovernmental collaborations, nonprofit and academic partnerships, local community organizing, and targeted investment.

In joining other major U.S. cities pursuing universal access, Chicago will advance a bold and transformative equity agenda that will help close racial/ethnic and geographic health disparities. Examples from other cities are instructive:

San Francisco: Through City ordinance, San Francisco requires businesses with 20 or more employees to contribute funds toward their employees' health care expenditures. City Council also established City Option, a program that provides limited health care services for 13,500 uninsured residents and manages medical reimbursement accounts for 186,000 others. Together with provisions of the Affordable Care Act and County leadership, healthcare insurance coverage in the City is nearly 100 percent.

San Francisco's universal health care plan eyed as model for California (April 3, 2017)
https://www.mercurynews.com/2017/04/02/san-franciscos-universal-health-care-plan-eyed-as-model-for-california

City's health care initiative shows success, but questions remain (Oct 24, 2017)
https://www.sfchronicle.com/restaurants/article/City-s-health-care-initiative-shows-success-12300530.php

New York City: City Hall announced in January ambitious plans to ensure health access to all New Yorkers beginning in the summer of 2019. The initiative relies on a robust Medicaid program in New York State, a local public option for low-income legal residents called MetroPlus, and a new program called NYC Care for undocumented individuals and those who remain uninsured. City government is supporting enrollment education and outreach efforts as well as helping connect residents to services via its 311 hotline.

New York City's 'Universal' Health Care Plan, Explained (January 9, 2019)
https://www.citylab.com/equity/2019/01/de-blasio-new-york-city-health-care-plan-universal-coverage/579787/

Philadelphia: Residents and activists have long championed universal coverage in the City. In 2008, voters adopted a universal healthcare ballot initiative. To help close access gaps, local researchers have mapped the "healthcare deserts" and City Hall has responded by helping to connect residents with available services, including the development of a new web-portal.

Get access to 100 services on the new website for Philly's health department: https://technical.ly/philly/2018/12/27/get-access-to-100-services-on-the-new-website-for-phillys-health-department/.
Racial Disparities in Geographic Access to Primary Care in Philadelphia
https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1612

What Chicago Does Best

- Public health data analyses
- Outbreak/emergency response
- Inspections
- Planning
- Coordination of HIV services
- 311 (can be expanded for health equity)

Areas for Improvement

- Coordination of existing behavioral healthcare services
- Strategies to bring needed services to scale (i.e, behavioral health; oral health care; sexual, and reproductive health; STIs; vaccinations; addressing conditions such as asthma and healthy weight management affected by environmental factors)
- Trauma and crisis services
- Safety and violence
- Infusing health equity in every City department and program
- Facilities and maintenance

Mayor Lightfoot can put Chicago on this path immediately:

- Make a bold, public commitment to study and implement steps to achieve universal healthcare access in Chicago.
- Instruct the Chicago Department of Public Health to define universal access goals and objectives as part of its planning efforts to update the City's Healthy Chicago roadmap to health equality.
- Marshal support from all City departments to identify ways to contribute to the attainment of universal access. Every department from 311, schools, libraries, and police to Family & Support Services, Park District, Facilities and Fleet Management, zoning and planning, arts and culture, housing, transportation, and environment have a role to play.
- Create a Deputy Mayor position over health and human services to coordinate planning, partnership and implementation efforts to achieve universal access.

Within the next year:

- Through rigorous and transparent planning and community mobilization, the next Healthy Chicago plan should define geographic gaps in care, needed strategies and services, and opportunities to build a culture of health in Chicago. The Robert Wood Johnson Foundation's (RWJF) framework could serve as a useful model to organize these efforts: https://www.rwjf.org/en/cultureofhealth.html.
- The plan should annotate assets in our cities, including its robust network of Federally Qualified Health Centers (FQHCs), hospital and academic systems, and city facilities and services that could play pivotal parts in a universal access initiative.
- In order to close the access gap for the uninsured, among other vulnerable populations, at a minimum Chicago will need to partner with Illinois Medicaid, Illinois state government, Cook County Health & Hospital System, FQHCs, and philanthropy.
- The City will need to determine what activities it is best suited to perform directly and which should be delegated or performed in partnership with nonprofit entities to achieve the best outcomes for the best price.

Where We Can Do Better
One Example

Howard Brown Health's 63rd St. Clinic, housed at CDPH's Englewood Neighborhood Clinic building, is emblematic of institutional community neglect, fomenting health disparities and inequities. Challenges in the past year:

- Interior temperatures exceeding 90 degrees forced unplanned closures 6 times last year; care was disrupted for hundreds of discouraged patients
- Lacking adequate HVAC, rising temperatures in the building overwhelmed a HBH refrigerator, spoiling more than $20,000 in vaccinations
- Water stained ceiling tiles are unsightly and crumbling; a tile fell on an employee last week
- Rodents emerge and interrupt patient visits
- Old pipes jetting from the weathered floors and holes in the walls create safety hazards for patients and staff
- The basement housing HBH's community oral health clinic is not accessible for patients in wheelchairs as the building remains out of compliance with ADA requirements
- HBH offers to operate the HVAC system or partner to make improvements have been roundly rejected
- The City should either maintain the building to high standards or partner with an entity that will do so or build a new facility on City land.

Long-term implementation:

- Chicago and Cook County should strive to attain recognition as a RWJF Prize-Winning Community (see: http://www.countyhealthrankings.org/sites/default/files/StrategiesInPrizeCommunities2013-2017.pdf)
- RWJF's paradigm for prize-winning communities describes important public health, access, and community wellness goals, including environmental community wellness.
- Chicago would benefit from a Deputy Mayor for Sustainability and Environmental Protection created in the Mayor's Office to steward an array of clean air, water, land, construction, and waste issues that play important roles in health equity initiatives.

Recommendations to Mayor-Elect Lightfoot from David Ernesto Munar, President/CEO of Howard Brown Health, serving as a co-chair for the Health and Human Services Transition Committee. April 16, 2019.

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TRANSFORMING COMMUNITY HEALTH CARE

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Donna Simmons
Chairman

Donna Thompson
Chief Executive Officer

Name: Donna Thompson **Date:** April 15, 2019

Transition Committee: Health and Human Services

Selected Initiative: Prioritizing mental health services by expanding capacity with behavioral health providers, increasing access to mental health service and fighting mental health stigma.

Background: With the expiration of the Chicago Department of Public Health (CDPH) strategic plan, (Healthy Chicago 2.0) in 2020, now is the time for the city to develop a new strategic plan to help lead the strategy, system coordination and policy priorities to support the health and wellness of all of Chicago's residents. Over the past three years, CDPH has made great strides in addressing the social determinants of health (housing, food insecurity, economic development and the build environment), increasing coordination between health care and human services, and building infrastructure to support data integration and coordination. Though much work has been achieved, there remain significant gaps requiring that in these key areas, CDPH hold the course.
Additionally, in the backdrop of health care access, delivery and health care insurance coverage in Chicago are the significant changes in health care coordination and population health management in the Department of Health and Family Services (HFS). A significant factor in ensuring CDPH can achieve and sustain the priorities outlined in its current strategic plan and in Mayor-elect Lightfoot's seven-point health and human services agenda is addressing the churn in Medicaid enrollment. Sustained health care insurance coverage is disrupted for many vulnerable residents through the Medicaid redetermination process, where coverage is lost and links to needed health care services are disrupted. As a result, population health management goals become difficult to achieve (including those associated with behavioral and mental health), and residents are not secured in a medical home where continuity of care is best provided.

The Potential Initiative: The Integrated Health Home model (IHH) is a key initiative that supports a fully-integrated form of care coordination for patients across their physical, behavioral and social care needs. Grounded in the patient centered medical home model, IHH establishes a single, joint care plan for the patient and the patient's care is coordinated across the continuum. Enhanced data interoperability and transparency is critical to this model of care, and enables full integration of physical and behavioral health.

ACCESS is currently piloting an IHH model that targets its patient population with high risk behavioral health needs. A significant proportion of these patients also have chronic physical health problems. The ACCESS IHH model includes partners that support stabilization and recovery services, including crisis management, mental health and substance abuse disorder treatment, employment and supportive housing services and inpatient services. In partnership with Catholic Charities, Trilogy, Gateway and Sinai Health System, the model also includes a trauma-informed approach that improves clinical outcomes and reduces the cost of

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TRANSFORMING COMMUNITY HEALTH CARE

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Donna Simmons
Chairman

Donna Thompson
Chief Executive Officer

care through shared efficiencies. This model builds on and improves patient engagement, behavioral health, population health management, addressing the social determinants of health, and provides links to ancillary services (dental care and pharmacy services).

What is happening today that we need to keep: IHH incorporates much of the transformational work of the Affordable Care Act, Medicaid expansion and care coordination to support broader access to physical and behavioral health care services. It requires a network of providers with integrated workflows, care coordination within a medical home, a core set of patient data shared within the network and ensured quality of care. The development of an IHH model with strong network partners builds on addressing the social determinants of care that supports patients'' health outside of the medical home. There are several primary care provider entities in Chicago working to create IHH within their networks, broadening the opportunities to expand this model across the priority to expand access to behavioral and mental health services.

What we need to implement in the next 100 days: Strengthening support and advocacy with HFS to address Medicaid redetermination, continuing the existing work of Healthy Chicago 2.0 that supports addressing the social determinants of health, coordination between health care and human services and expanding data integration. These are significant factors in expanding behavioral and mental health services between providers and payers.

What we can plan for longer-term implementation: Continuing to serve as a neutral convener to bring key behavioral and mental health service providers, primary care providers and social service/human service partners together with the regulatory and policy implementing agencies (Medicaid and the Department of Human Services) to collaborate on best practices, amending and expanding existing policies to expand access to care for low-income patients.

What challenges we might encounter in executing on this initiative: Current challenges at the city and state level include identifying behavioral and mental health providers willing to engage in providing care to patients within the safety net. Barriers to competitive reimbursement rates for behavioral and mental health services from Medicaid and stigma associated with low-income patients remain and are significant impediments to broadening access.

Name: Esther Corpuz

Transition Committee: Public Health

Initiative: Access to Health care for all Chicagoans & Illinoisans--Medicaid/Medicare for All (including undocumented population)

The belief that health care is a basic right and that all people have access to health care includes a path to health insurance coverage – coverage for all including the undocumented, homeless, low-income working poor and other hard to reach communities.

Our state and local governments are currently paying for healthcare services of uninsured Illinoisans, as are community health care centers and safety net hospitals who serve a disproportionately large number of low income patients. Expanding coverage would fill the fiscal gaps that Chicago & Illinois hospitals face by reductions in Medicaid Disproportionate Share Hospital payments. Privately, insured individuals and families pay more every year in premiums to cover the costs of those who cannot pay for their care. Providing insurance to the remaining uninsured would help bring fiscal relief to overburdened safety net health centers and hospitals as well as help bend the cost curve on premiums. It would create a healthier, more productive pool of employees and decrease the risk of communicable diseases. A successful initiative implemented in 2006 was the All-Kids program which provides low-income families Medicaid for the children (ages 0-18) regardless of immigration status – **a program we must preserve**. Illinois now has the second highest rate of health coverage for Latino children in the nation (95.5%). All Kids has also resulted in Illinois having one of the highest rates of health coverage for ALL children. (96.6%) New York City has already begun providing healthcare reimbursement for the 600,000 uninsured people living in the city. The program is called NYC Care.

Expanding access to health care - For decades, Federally Qualified Health Centers (FQHC's) have played a crucial role in ensuring access to quality primary and preventative care to 800 thousand Chicagoans in 150 locations and 1.4 million patients across the state of Illinois. Utilizing a team-based, comprehensive primary care service delivery model used by nearly 1,400 HRSA-funded health centers nationwide continues to provide a strong framework for integrated behavioral health and primary care services, and for addressing substance use disorders (SUD's) including Opioid Use Disorder (OUD). The model's use of patient centric approaches, care management, and continuing mental health and SUD services. As a result, community health centers are well-position to address the existing unmet needs.

They demonstrate that communities can improve health, reduce health disparities, effectively address a multitude of costly and significant health problems, including access to behavioral health services, and care to undocumented individuals who were not included in the ACA. FQHC's board governance, require a minimum of 51% of the health center board members be patients served by the health center – promoting diversity and inclusion. I would advocate that we preserve funding for FQHC's and utilize the existing infrastructure that includes federal funding to expand health centers in underserved communities areas identified as "in need" communities.

Expand funding for school based health care centers. A school-based health center (SBHC) brings a shared commitment between community schools and a community based health care centers. When children and adolescents have access to high quality health care, they are better equipped to learn, thrive in the classroom and succeed. SBHC are an effective and low cost model for delivering comprehensive health care that includes behavioral health, primary care, oral health, health promotion, nutrition education and reproductive counseling and prenatal care. School based health centers are also equipped to care for non-students or community residents. The ultimate goal is to create a culture of health within the school.

Immediately, Mayor elect Lightfoot can use her power and influence to support HB0072 which expands health coverage for Deferred Action for Child Arrivals (DACA) recipients and Legal Permanent Residents (Green Card Holders). Currently, both DACA recipients and LPR's (< 5 years) pay state and federal taxes, yet do not have access to Medicaid health coverage which they assist in funding. Studies show that expanding Medicaid access results in significant job creation at the state level as well as an increase in labor force participation. By expanding eligibility to both DACA recipients and LPR's will improve health outcomes for thousands of vulnerable, low-income individuals in our communities. It will increase economic prosperity through relieving financial burdens. Individuals that prosper have a direct impact on education, safety and overall lifestyle well-being.

HEARTLAND ALLIANCE

MEMORANDUM

TO: Mayor-Elect Lori Lightfoot
FROM: Evelyn Diaz, Heartland Alliance
Transition Committee: Health and Human Services

Initiative: Reallocate flexible funding to address the most critical unmet needs in Chicago's most distressed communities and challenge the private and philanthropic sectors to increase their investments.

Description: Mayor-elect Lightfoot has a special opportunity and a small window to create a new federal 5-Year Consolidated Plan[1] to reprioritize and reallocate approximately $114 million in federal grant funds and over $100 million in city Corporate Funds (from DFSS and CDPH budgets) to ensure those funds are being put to the highest and best use in the places where they are needed most. This initiative would strategically and equitably reprioritize these and other funding allocations to expand programs and services aimed at addressing violence, jobs, affordable and supportive housing, and trauma in the communities with the highest needs.

Infusion of Values: The equitable distribution of limited resources is the most powerful way to activate the Mayor-Elect's values of equity and transformation and would demonstrate a direct and immediate commitment to addressing persistent inequities that have plagued Chicago's south and west side communities. Chicago residents most impacted by high concentrations of housing instability; chronic and astronomical unemployment; and gun violence have been vocal, persistent, and clear about what new investments their communities need--housing, jobs, safety, and healing top the list. It is not clear that their voices have been included meaningfully in developing spending priorities in the past. Reprioritizing the city's health and human services budgets to address those needs and doing so in way that is inclusive and strategically targeted would go a long way toward demonstrating the values of equity, inclusion, and transformation.

What's Happening Today? The City's current investments in affordable housing (including supportive housing), transitional jobs, re-entry services, mental health services, and community-based, street-level violence intervention are insufficient to meet the need, and the social costs of de-prioritizing these programs over time have become untenable in the communities most affected. The city's 5-year Consolidated Plan is expiring and is neither inclusive in how it is developed nor reflective of the most critical needs in Chicago's most economically distressed communities. Each year, city departments leave grant money on the table, failing to fully spend grants by the year's end. Additionally, the City's Corporate Fund for CDPH and DFSS (over $100 million combined) reflects the priorities of prior administrations and could be re-examined and re-prioritized to reflect the values and priorities of Mayor-Elect Lightfoot's administration.

First 100 Days:

- Determine when the new 5-year Consolidated Plan is due to HUD; order a complete accounting of the City's current funding allocations for community development and social services (who is

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[1] The City of Chicago receives annual formula grants from HUD in exchange for a 5-Year Consolidated Plan that spells out the City's community development priorities for CDBG, ESG, HOME and HOPWA funding.

getting paid to do what, where, and for how many) and the results we are getting for these investments; identify and analyze all flexible funding sources.

- Establish a set of priorities in affordable housing, supportive housing, transitional jobs, trauma recovery, and violence intervention based on recommendations from the already-existing citywide coordinating efforts in these areas[2] as well as the recent feedback from Transition Committees.
- Determine the priority geographic areas and program models to fund.
- Announce the City's new investments in the areas of principal concern to distressed communities as part of the 2020 Budget.
- Spend every penny. Insist that 100% of grant dollars are spent, including allowing "up to" grant awards that exceed budget to account for underspending (e.g., overbooking); providing incentives for providers to fully spend their allocations; and allowing special year-end re-granting to smaller community-based organizations to expend unspent grant dollars for pre-approved uses.

For Longer-Term Implementation:

- Identify ways to sustain the investments over the long-term, including establishing multi-year fund-match partnerships with philanthropy and private sector. This will keep rigor high and commitments durable regardless of leadership transitions.
- Strengthen data infrastructure to collect, analyze, and share data from communities on the return on these investments.
- Strengthen capacity of community-based organizations to grow and improve program quality. We should be able to measure improved system performance annually.
- Create an Innovation Fund and procurement channel to ensure new, creative ideas have a path into the administration and way to be piloted and tested.
- Engage research institutions to conduct rigorous evaluation of program interventions to help figure out the "sweet spot" (who benefits the most) for specific program models.

Challenges:

- A strategic and equitable reallocation of resources will cause considerable consternation. Many of the funding sources to be re-prioritized and reallocated are carefully scrutinized by local, county, and state elected representatives who are likely to protest any reallocation they believe won't benefit their district. Community-based organizations that were once the beneficiary of these funding sources will be unhappy about no longer being funded. Creating a "ramp down" year would help those organizations adjust.
- Long-term effectiveness requires long-term investments that remain focused, data driven, and impervious to political pressures, while ensuring private and philanthropic investors stay the course.
- Lack of a data infrastructure to measure and track outcomes and impact over time and across departments.
- Lack of strong evidence about what interventions work best and for whom, and significant capacity constraints at the community provider level to scale what works.

[2] Bring Chicago Home (Chicago Coalition for the Homeless); Re-entry Housing Task Force (Heartland Alliance & Chicago CRED); Transitional Jobs and Anti-Violence (MOVP Advisory Council, inVEST campaign); Violence Reduction Working Group (Mayor's Office, Chicago CRED).

Health and Human Services Transition Committee

Ensure all Chicagoans have access to comprehensive care

The incoming administration should put Chicago on a path to guarantee access to vital and comprehensive healthcare services for all Chicagoans. This audacious objective is attainable through City Hall leadership, intergovernmental collaborations, nonprofit and academic partnerships, local community organizing, and targeted investment.

In joining other major U.S. cities pursuing universal access, Chicago will advance a bold and transformative equity agenda that will help close racial/ethnic and geographic health disparities. Examples from other cities are instructive:

San Francisco: Through City ordinance, San Francisco requires businesses with 20 or more employees to contribute funds toward their employees' health care expenditures. City Council also established City Option, a program that provides limited health care services for 13,500 uninsured residents and manages medical reimbursement accounts for 186,000 others. Together with provisions of the Affordable Care Act and County leadership, healthcare insurance coverage in the City is nearly 100 percent.

San Francisco's universal health care plan eyed as model for California (April 3, 2017)
https://www.mercurynews.com/2017/04/02/san-franciscos-universal-health-care-plan-eyed-as-model-for-california

City's health care initiative shows success, but questions remain (Oct 24, 2017)
https://www.sfchronicle.com/restaurants/article/City-s-health-care-initiative-shows-success-12300530.php

New York City: City Hall announced in January ambitious plans to ensure health access to all New Yorkers beginning in the summer of 2019. The initiative relies on a robust Medicaid program in New York State, a local public option for low-income legal residents called MetroPlus, and a new program called NYC Care for undocumented individuals and those who remain uninsured. City government is supporting enrollment education and outreach efforts as well as helping connect residents to services via its 311 hotline.

New York City's 'Universal' Health Care Plan, Explained (January 9, 2019)
https://www.citylab.com/equity/2019/01/de-blasio-new-york-city-health-care-plan-universal-coverage/579787/

Philadelphia: Residents and activists have long championed universal coverage in the City. In 2008, voters adopted a universal healthcare ballot initiative. To help close access gaps, local researchers have mapped the "healthcare deserts" and City Hall has responded by helping to connect residents with available services, including the development of a new web-portal.

Get access to 100 services on the new website for Philly's health department: https://technical.ly/philly/2018/12/27/get-access-to-100-services-on-the-new-website-for-phillys-health-department/.
Racial Disparities in Geographic Access to Primary Care in Philadelphia
https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1612

What Chicago Does Best

- Public health data analyses
- Outbreak/emergency response
- Inspections
- Planning
- Coordination of HIV services
- 311 (can be expanded for health equity)

Areas for Improvement

- Coordination of existing behavioral healthcare services
- Strategies to bring needed services to scale (i.e, behavioral health; oral health care; sexual, and reproductive health; STIs; vaccinations; addressing conditions such as asthma and healthy weight management affected by environmental factor)
- Trauma and crisis services
- Safety and violence
- Infusing health equity in every City department and program
- Facilities and maintenance

Mayor Lightfoot can put Chicago on this path immediately:

- Make a bold, public commitment to study and implement steps to achieve universal healthcare access in Chicago.
- Instruct the Chicago Department of Public Health to define universal access goals and objectives as part of its planning efforts to update the City's Healthy Chicago roadmap to health equality.
- Marshal support from all City departments to identify ways to contribute to the attainment of universal access. Every department from 311, schools, libraries, and police to Family & Support Services, Park District, Facilities and Fleet Management, zoning and planning, arts and culture, housing, transportation, and environment have a role to play.
- Create a Deputy Mayor position over health and human services to coordinate planning, partnership and implementation efforts to achieve universal access.

Within the next year:

- Through rigorous and transparent planning and community mobilization, the next Healthy Chicago plan should define geographic gaps in care, needed strategies and services, and opportunities to build a culture of health in Chicago. The Robert Wood Johnson Foundation's (RWJF) framework could serve as a useful model to organize these efforts: https://www.rwjf.org/en/cultureofhealth.html.
- The plan should annotate assets in our cities, including its robust network of Federally Qualified Health Centers (FQHCs), hospital and academic systems, and city facilities and services that could play pivotal parts in a universal access initiative.
- In order to close the access gap for the uninsured, among other vulnerable populations, at a minimum Chicago will need to partner with Illinois Medicaid, Illinois state government, Cook County Health & Hospital System, FQHCs, and philanthropy.
- The City will need to determine what activities it is best suited to perform directly and which should be delegated or performed in partnership with nonprofit entities to achieve the best outcomes for the best price.

Where We Can Do Better
One Example

Howard Brown Health's 63rd St. Clinic, housed at CDPH's Englewood Neighborhood Clinic building, is emblematic of institutional community neglect, fomenting health disparities and inequities. Challenges in the past year:

- Interior temperatures exceeding 90 degrees forced unplanned closures 6 times last year; care was disrupted for hundreds of discouraged patients
- Lacking adequate HVAC, rising temperatures in the building overwhelmed a HBH refrigerator, spoiling more than $20,000 in vaccinations
- Water stained ceiling tiles are unslightly and crumbling; a tile fell on an employee last week
- Rodents emerge and interrupt patient visits
- Old pipes jetting from the weathered floors and holes in the walls create safety hazards for patients and staff
- The basement housing HBH's community oral health clinic is not accessible for patients in wheelchairs as the building remains out of compliance with ADA requirements
- HBH offers to support control of HVAC or partner to make improvements have been roundly rejected
- The City should either maintain the building to high standards or partner with an entity that will do so or build a new facility on City land.

Long-term implementation:

- Chicago and Cook County should strive to attain recognition as a RWJF Prize-Winning Community (see: http://www.countyhealthrankings.org/sites/default/files/StrategiesInPrizeCommunities2013-2017.pdf)
- RWJF's paradigm for prize-winning communities describes important public health, access, and community wellness goals, including environmental community wellness.
- Chicago would benefit from a Deputy Mayor for Sustainability and Environmental Protection created in the Mayor's Office to steward an array of clean air, water, land, construction, and waste issues that play important roles in health equity initiatives.

Recommendations to Mayor-Elect Lightfoot from David Ernesto Munar, President/CEO of Howard Brown Health, service as a co-chair for the Health and Human Services Transition Committee. April 16, 2019.

Name: Erica Salem, MPH

Transition Committee: Health & Human Services

Prompt: Define and operationalize the optimal role for CDPH and DFSS

Initiative: Establish incubators on the city's south and west sides to increase opportunities for grant funding for and services delivered by health and social service agencies based in vulnerable communities.

Infusion of Values: The proposed initiative will strength the alignment between communities facing the most serious health and human services challenges and the locations of agencies funded to address them. It will increase the inclusion of smaller, less resourced organizations in the delivery of city-supported services and programs, a move that will also create a more equitable distribution of funds and increase diversity among providers.

Happening Today: Some small community-based agencies with established community ties and the ability to deliver programs and services well at times lack the financial resources and/or capacity to write competitive grants, evaluate funded programs and/or effectively administer and manage grant-funded programs. Because of this their applications for City-administered grant funding may fall short in the proposal review process and dollars may not make there way to applicants based within communities in greatest need.

100 Days: Identify two or more well-established and managed community-based organizations (west and south sides) to support local agencies, and establish a process for participation and an infrastructure to provide grant, evaluation and management support as needed and requested.

Longer-Term Implementation: Depending on outcomes of 100-day activities, strategies for longer-term implementation provided by incubators and supported by the City might include:

- Providing direct grant writing services to small community-based agencies
- Providing grant-required program evaluation services
- Delivering backbone organizational support in areas of administration and management, including incubators serving as fiscal agents
- Providing technical assistance and capacity building services to local agencies that have never received grant funding from the City.

Challenges: Because participation by small applicant agencies could be completely voluntary few challenges are expected. The City would have to identify and provide funding to support the infrastructure and services provided by incubator sites.

Prompt: Define and operationalize the optimal role for CDPH and DFSS

Initiative: Develop and implement a strategy to eliminate racial disparities in childhood asthma

Infusion of Values: This initiative directly pertains to issues of equity in health and will transform the City's approach to childhood asthma by engaging multiple City departments and sister agencies in a coordinated approach to reducing racial/ethnic disparities. Publicly available annual reporting on emergency room visits for childhood asthma will provide transparency and help hold the City accountable for tackling this issue.

Happening Today: CDPH has prioritized the reduction of asthma disparities in its Healthy Chicago 2.0 plan. Currently the Chicago Department of Public Health (CDPH) makes asthma-related data available to the public and is available to provide technical assistance to stakeholders using these (and other) data. Department staff participate in asthma-related policy development activities as requested by stakeholder agencies. Despite vast racial disparities, for the past 30 years and possibly longer, the City Council has not appropriated any funding for CDPH or its community partners to address asthma. Outside of government, a small handful of community partners deliver asthma self-management training to students with asthma in schools and through home-visits by community health workers, and provide training to parents and staff from schools, the Chicago Park District, childcare providers and other caregivers who spend time with children with asthma.

100 Days: The Mayor's Office should establish an inter-agency working group and charge them with developing a series of cross-cutting strategies to include: remediation, education and data sharing to develop and implement a coordinated response to both childhood and adult asthma. The group would consist of CDPH, CDFSS, Planning & Development, Transportation and Buildings (and new Departments of Housing and Environment if established) and the Chicago Public Schools, CTA, Housing Authority, and Park District. A report would be developed within the first 100 days of Mayor Lightfoot's administration and implementation would begin immediately.

This approach could build on an inter-agency effort that resulted in a Health in All Policies Task Force that had not previously focused on asthma. It could also be expanded to address other health and public health priorities that would benefit from a multi-agency coordinated response.

Longer-Term Implementation: Several strategies for longer-term implementation include:

- Working with pharmaceutical companies to secure free albuterol which schools are now allowed to stock in the event of emergencies. Senator Durbin has recently secured epinephrine through the FDA and that may serve as another vehicle for obtaining albuterol.

- Provision of City funding for community-based asthma management work. Funds could be allocated – in alignment with Healthy Chicago – through a competitive RFP process managed by the Chicago Department of Public Health. Elements of such a program include: community health workers, and school-based asthma management education for both students with asthma and their caregivers.

- Expanding the responsibilities of CDPH's environmental lead inspectors to include assessments of asthma triggers such as mold and rodent droppings, consistent with a more comprehensive "Healthy Homes" model. This would require an increase in inspectors.
- Implementing strategies around transportation electrification, which would will greatly reduce urban air pollution (a significant contributor to asthma) caused by motor vehicles:
    - Convert CTA to an all-electric fleet to reduce air pollutants by saving nearly 55,000 tons of greenhouse gases each year, equivalent to taking more than 10,000 cars off the roads.[i] CTA has noted that savings include $25,000 annually in net fuel costs per bus ($300,000 per bus over the expected bus lifespan), as well as indirect savings of approximately $55,000 per bus per year in respiratory and other health costs.[ii]
    - Aggressively pursue $10 867,968 in Illinois EPA Volkswagen settlement funds allocated to electric school bus purchases and $10,867,968 in funding available for electric freight trucks.
    - Ensure that the renewal of the ComEd franchise agreement with the City that expires at the end of 2019 includes provisions to adequately supply electricity for public-serving fleets like CTA, school buses and city garage locations.
    - Establish an ordinance that requires new commercial freight warehouse operations and other facilities served by freight truck traffic built in the city to be electric truck recharging ready.
- Conducting an internal audit to assess compliance with the 2011 Chicago Clean Diesel Construction Ordinance, update the ordinance to reflect and incorporate technological advances that result in cleaner air like electrification, and expand ordinance requirements to all public and private projects undertaken in the city.
- Enacting policies to reduce tobacco and exposure to second-hand smoke.

Prompt: Define and operationalize the optimal role for CDPH and DFSS

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Department staff participate in asthma-related policy development activities as requested by stakeholder agencies. Despite vast racial disparities, for the past 30 years and possibly longer, the City Council has not appropriated any funding for CDPH or its community partners to address asthma. Outside of government, a small handful of community partners deliver asthma self-management training to students with asthma in schools and through home-visits by community health workers, and provide training to parents and staff from schools, the Chicago Park District, childcare providers and other caregivers who spend time with children with asthma.

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This approach could build on an inter-agency effort that resulted in a Health in All Policies Task Force that had not previously focused on asthma. It could also be expanded to address other health and public health priorities that would benefit from a multi-agency coordinated response.

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- Expanding the responsibilities of CDPH's environmental lead inspectors to include assessments of asthma triggers such as mold and rodent droppings, consistent with a more comprehensive "Healthy Homes" model. This would require an increase in inspectors.

- Implementing strategies around transportation electrification, which would will greatly reduce urban air pollution (a significant contributor to asthma) caused by motor vehicles:

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- Conducting an internal audit to assess compliance with the 2011 Chicago Clean Diesel Construction Ordinance, update the ordinance to reflect and incorporate technological advances that result in cleaner air like electrification, and expand ordinance requirements to all public and private projects undertaken in the city.
- Enacting policies to reduce tobacco and exposure to second-hand smoke.

Challenges: While many City agencies collaborate well, some may not see a role for themselves in health equity and may resist participating in an inter-departmental approach to reducing asthma disparities. Funding for additional lead inspectors will likely not be available through state or federal grants and the costs of electrifying the CTA bus fleet are still unknown but being studied. ComEd may resist inclusion of additional electricity infrastructure to support charging needs for electric vehicles.

Prompt: Define and operationalize the optimal role for CDPH and DFSS

Initiative: Develop and implement a Tobacco Policy and Program Agenda to reduce youth and adult smoking rates and position Chicago to maintain its national reputation as a leader in this space.

Infusion of Values: The tobacco industry has a sordid history of preying upon minority and teen populations through deceptive marketing and product sampling. This initiative pertains to issues of equity in health by targeting cessation services to those communities with high tobacco use rates and enacting policy measures to counteract tobacco industry efforts. Publicly available data on tobacco use rates for both youth and adults in Chicago will provide transparency and help hold the City accountable for tackling this issue.

Happening Today: In the past several years the City of Chicago has been a leader in reducing youth smoking. Policies that have made cigarettes less affordable and less accessible have led to a *59% decrease* in Chicago's youth smoking rates since 2011. Conversely, adult smoking rates have largely remained level, and in some neighborhoods have increased, during this period. A recent and significant rise in flavored electronic cigarettes and other flavored tobacco products threatens progress made. In 2017, 36.6% of Chicago's high school students reported having used an e-cigarette. Nationally, a recent

78% increase in youth e-cigarette use prompted the U.S. Food and Drug Administration to declare youth use of e-cigarettes an epidemic. For the past three years, the Chicago Department of Public Health (CDPH) has funded community-based partners to deliver cessation programs in the communities with the highest smoking rates - primarily south and west side low-income communities of color. That funding is due to lapse at the end of calendar year 2019.

100 Days: The Mayor's Office should direct CDPH to develop a tobacco policy and program agenda within the first 100 days, and then to immediately begin implementation, in partnership with community stakeholders. In addition to reviewing youth tobacco initiation, the plan should also address strategies for lowering tobacco use among vulnerable populations including those with low incomes, LGBTQ populations, communities of color and persons with mental illness.

Chicago has advanced many bold tobacco policies in the past. Enforcement of these policies should be reviewed particularly with regards to tax evasion and compliance with the existing flavored sales restrictions near schools. This could provide an opportunity to raise public awareness of the addictive nature and health risks of tobacco products including e-cigarettes.

Longer-Term Implementation: Several strategies for longer-term implementation include:

- Continuing grant support for current targeted, community-based cessation efforts focused on vulnerable adult populations.
- Banning flavored tobacco sales Citywide. As more than 80% of youth who try tobacco start with flavored products such as cotton candy e-cigarettes or chocolate cigarillos[v], Chicago's current flavored sales restriction should be extended citywide, not just within a 500-foot radius of schools.

- Decreasing tobacco retail density, as the number of tobacco retailers within a community impacts youth smoking rates and overall tobacco use. Limit the geographic density and proximity of tobacco retail licenses for specialty shops and other kinds of tobacco sellers.

- Prohibiting the sale by pharmacies of tobacco and nicotine delivery products not approved by the FDA. Following CVS' 2014 decision not to sell cigarettes, CVS customers were 38% more likely to stop buying cigarettes.[vi] The average smoker in states where CVS operates purchased five fewer cigarette packs and, in total, approximately 95 million fewer packs were sold.[vii]

- Increasing enforcement of existing tobacco ordinances including the flavored sales restriction and as well as increasing enforcement actions on illegal or improperly stamped sales of cigarettes and other tobacco products by retailers. High tech tax stamps could help ease enforcement on tobacco sales in Chicago.

- Implementing communication strategies within Chicago schools regarding the addictive nature and dangers of tobacco use including e-cigarettes and vaping products.

Challenges: Chicago has had an aggressive policy agenda addressing tobacco use through taxation, purchase age restrictions, flavored sales restrictions, and more. The State is considering raising the tax on cigarettes and placing a tax on e-cigarettes and vaping products; those taxes will be collected in

Chicago as well. Because of this the political environment may be reluctant to implement further restrictions on the tobacco industry and their vendors. Some alderman and interest groups may resist changes due to a desire to protect retailers in their wards. Consistent with past practices, representatives of the tobacco and e-cigarette industries will lobby City Council members to oppose policies designed to reduce tobacco use.

Enhanced communication to young people as well as increased enforcement of existing ordinances can have an impact in the short term regardless of the political climate. Support for cessation services is typically seen as a solid positive because of the projected health outcomes.

Prompt: Define and operationalize the optimal role for CDPH and DFSS

Initiative: Create a CDBG-supported *Mayor's Public Safety and Violence Prevention Fund* to be administered by the newly-created Office to ensure a public health and collaborative approach to violence prevention.

Infusion of Values: The initiative will hold multiple City agencies accountable for working together to use their respective areas of expertise and constituencies to inform and support a comprehensive approach to violence reduction in Chicago. With additional financial support it will also result in a process that fosters greater inclusion of community agencies in a citywide approach, a more diverse set of stakeholders, and resources to support community involvement in solving the problems of violence, including gun violence in Chicago. A publicly posted annual report from the Mayor's Office of Violence Prevention that identifies funded projects and outcomes will contribute to transparency.

Happening Today: Currently, I believe there is neither a significant process nor resources for a multi-agency coordinated approach to violence prevention and reduction. DFSS provides some grants domestic violence and CDPH supports select violence prevention programs, primarily focused on youth and resiliency. Other City agencies have previously funded agencies to address elder abuse and violence against people with disabilities.

100 Days: Identify a source for an initial level of funding and establish parameters for the administration of and City agency participation in the Fund.

Longer-Term Implementation: Strategies for longer-term implementation might include:

- Developing a single RFP reflective of a multi-pronged, crossing cutting approach to a community-based response to public safety and gun violence.

- Establishing a proposal review process that unites multiple City departments in decision-making and can ensure a continuum of approaches (from prevention through intervention) is considered.

- Exploring vehicles for increasing revenues to support violence prevention and mental health services. Potential areas for consideration might include:

- Community benefits or other dollars from local hospitals which see large volumes of gunshot victims or other victims of violence,

- Exploration of a partnership between the City of Chicago and a local Native American Indian Tribe to establish and operate a casino. As sovereign nations, casinos operated by Native Americans are tax-exempt and could generate a greater share of resources to be kept in Chicago.

Challenges: A review of current allocations of CDBG funds would need to be conducted to identify areas from which funds might be redirected to support this initiative.

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[i] Alana Miller and Hye-Jin Kim, Frontier Group Jeffrey Robinson and Matthew Casale, U.S. PIRG Education Fund . Electric buses: Clean transportation for healthier neighborhoods and cleaner Air. May 2018. https://uspirg.org/sites/pirg/files/reports/Electric%20Buses%20-%20National%20-%20May%202018%20web.pdf

[ii] Chicago Transit Authority website. https://www.transitchicago.com/electricbus/

[iii] Alana Miller and Hye-Jin Kim, Frontier Group Jeffrey Robinson and Matthew Casale, U.S. PIRG Education Fund . Electric buses: Clean transportation for healthier neighborhoods and cleaner Air. May 2018. https://uspirg.org/sites/pirg/files/reports/Electric%20Buses%20-%20National%20-%20May%202018%20web.pdf

[iv] Chicago Transit Authority website. https://www.transitchicago.com/electricbus/

[v] Campaign for Tobacco Free Kids. The flavor trap: How tobacco companies are luring kids with candy-flavored E-cigarettes and cigars, March 15, 2017 .

[vi] Polinski, J., et al. Impact of CVS pharmacy's discontinuance of tobacco sales on cigarette purchasing (2012–2014). American Journal of Public Health, April 2017.

[vii] CVS Health. We quit tobacco and here's what happened. https://cvshealth.com/thought-leadership/cvs-health-research-institute/we-quit-tobacco-heres-what-happened-next

RESILIENCE
EMPOWERING SURVIVORS ENDING SEXUAL VIOLENCE

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To: **Mayor-Elect Lori Lightfoot**
From: **Erin Walton, Executive Director of Resilience; Health & Human Service Committee Member**
Objective: Help Build Resilient Communities
Initiative: Addressing Gender-based violence through prevention and improved response

Sexual violence has spurred national conversation following the #MeToo and #TimesUp movements and at the local level with high profile celebrity cases like R Kelly and reports of hundreds of unaddressed child sex abuse experiences at Chicago Public Schools. Chicago is not unique to this epidemic, national statistics show that nearly 1 out of every 6 American women has been the victim of an attempted or completed rape in her lifetime and about 3% of American men—or 1 in 33—have experienced an attempted or completed rape in their lifetime.

According to the US Census Bureau from 2016, the city of Chicago has an estimate population of 2,704,958. According to the Chicago Police Department, in 2017, there were a total of 2,733 Criminal Sexual Assault and Criminal Sexual Abuse Incidents reported. This number only recognizes a small percentage of sexual assault as the vast majority go unreported, with only 310 out of every 1,000 sexual assaults being reported to police. For marginalized communities, the numbers of unreported sexual assaults increases due to homo/bi/transphobias, sexism, racism, police brutality, criminalization of substance use, mistreatment and discrimination from healthcare providers and law enforcement, and a fear of not being believed, or actually not being believed.

Adequate response to sexual violence begins with ensuring trauma-informed responses to survivors of all backgrounds. Additionally it means listening to survivors and those that work with survivors on their needs for long term healing and justice as well putting measures in place to analyze tangible progress on outcome based results of disclosers.

Chicago Police Response and Prevention:
Currently, Chicago has two multi-disciplinary teams that address sexual assault and domestic violence. These teams bring together the Cook County State's Attorney office, Chicago Police Department, and selected community based rape crisis and domestic violence programs to improve the criminal justice response to sexual assault survivors. These MDTs include unprecedented opportunities to review case files and evaluate data as well as to develop clear protocol, increase a trauma-informed understanding of sexual assault victims, cross-train and increase access to services for survivors and their loved ones. Previously the Mayor's Office participated on these teams and the importance of their participation, particularly as it pertains to Chicago Police oversight is imperative. While progress has been made through the MDTs there is still a need for stronger integration of community based support services like co-located rape crisis and domestic violence advocates in detective areas. Additionally, while state law and local efforts have improved training for Chicago Police, more training is needed on working with survivors and particularly those from marginalized communities of color, LGBTQ, children and immigrants. The response to these groups continues to be further complicated when sex work, substance abuse or mental health is also present.

Survivors deserve timely resolution of these cases if reported. Currently the turnaround time for DNA from a sexual assault evidence collection is a year and half or longer. Additionally, the arrest rate for adult cases of sexual assault hovers around 14%. While the mental trauma of leaving survivors in limbo communicates to victims in our community that sexual assault is not a priority, lack of speedy DNA results further exacerbates the issue leaving rapists free to harm others. Rape cases involving children, non-verbal survivors, survivors with disabilities and those who were assaulted through drug facilitation suffer greatly in this lengthy process. These cases are often dependent on DNA evidence to link their attacker to what the survivor has reported. More resources are needed to ensure crime laboratories are equipped to end the backlog of untested DNA evidence in an effort towards improving arrest rates.

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The Mayor's office should also have an active role in promoting the jurisdiction given to the Civilian Office of Policy Accountability in overseeing officer involved cases of sexual and domestic violence.

Chicago Public Schools Response and Prevention:
Chicago Public Schools recently started the Office of Student Protections. While CPS has begun meeting with community members on prevention and response, the Mayor's Office can play a pivotal role in ensuring community based supports are available separate from the important but investigative role of the Chicago Children's Advocacy Center and outside of the CPS system.

Additionally, prevention education is critical in changing a rape culture defined by homo/bi/transphobia, sexism, racism, criminalization of survivorship, mistreatment and discrimination from schools, healthcare providers and law enforcement.

Strategic prevention education programming for CPS by community based providers with expertise in the area must be implemented city-wide.

Chicago Community-based Response and Prevention:
Rape Crisis and Domestic Violence Agencies in the City of Chicago serve thousands of survivors and their loved ones each year through crisis intervention advocacy and counseling services as well as prevention education services. The City of Chicago provides no financial support to community based rape crisis centers who provide 24 hour crisis response and prevention education services. And while domestic violence services receive some funding, more shelters are needed in Chicago.

These agencies also provide professional training to law enforcement, medical providers and school professionals often at no cost.

Summary of Recommendations (First 100 Days):
- The Mayor of Chicago meets with Illinois State Police to explore immediate options in addressing the backlog of untested evidence collection kits from Chicago.
- The Mayor's Office meets with Chicago Police to discuss current arrest rates on sexual assault cases.
- The Mayor's Office partners with the Chicago Department of Public Health in an awareness campaign on consensual sexual experiences and screening for domestic violence, sexual assault and human trafficking by medical professionals in hospitals and community health centers as a part of a routine exam as part of a public health response to gender based violence.
- The Mayor's office creates a full-time Gender Based Violence Policy advisor that reports directly to the Mayor and oversees all issues pertaining to gender-based violence and work done with Chicago Police, Chicago Public Schools and community based domestic violence and rape crisis centers. This position (or a designee) should participate on the MDT and have adequate staffing to help ensure there is concentrated focus on response and prevention.
- Begin to discuss city-wide expansion of prevention education programming for CPS by community based providers with expertise

Summary of Longer Term (100+ Days) Recommendations:
- More training for Chicago Police working with survivors, particularly survivors from marginalized communities of color, LGBTQ, children and immigrants.
- Expansion of services like co-located rape crisis and domestic violence advocates in detective areas.
- Provide direct funding for rape crisis services to support prevention and response to sexual assault.

Illinois Children's Healthcare Foundation

To: Health and Human Services Transition Committee
Mayor-Elect Lightfoot

From: Heather Higgins Alderman, President ILCHF

Subject: Health and Human Services Transition Committee Memo

Date: April 16, 2019

OBJECTIVE: Ensure all Chicagoans have access to integrated health services, especially where data show gaps exist.

INITIATIVE: Plan, implement, support and evaluate comprehensive children's System of Care projects in three or more communities in Chicago.

ALIGNMENT WITH VALUES EQUITY, TRANSPARENCY, ACCOUNTABILITY, DIVERSITY, INCLUSION AND TRANSFORMATION: The **definition** of System of Care, and the Core Values and Guiding Principles of System of Care are in alignment with the Mayor-Elect Lightfoot's values. A System of Care has been defined as follows:

> *"A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life." (Stroul, Blau & Friedman; 2010, Updating the System of Care concept and philosophy)*

While the definition above focuses on children's mental health, System of Care is a conceptual framework. We are recommending using this framework to implement a fully holistic system which integrates child serving systems including primary and mental health care, oral health and vision services, education, early childhood, recreation and community safety.

The **Core Values** of a System of Care are:

1. Family-driven and youth-guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
2. Community-based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

By focusing specifically on youth, their family and their community, the values of equity, diversity and inclusion can be embedded into all aspects the work. Moreover the Guiding Principles accountability, transparency are found within the Guiding Principles of System of Care (available here). Finally,

designing the initiative to require operational and financial sustainability would result in permanent and lasting change leading to the transformation of the communities implementing these Systems of Care.

WHAT WE NEED TO KEEP:

1. All integrated services which are currently working.
2. Continue to draw upon numerous studies and data sources to inform this work, including the Chicago Health Atlas, the recently published Risk and Reach Report and for oral health, the State Wide Oral Assessment.
3. There is significant experience both nationally and locally in terms of planning and implementing System of Care projects for children's health. Locally, Illinois Children's Healthcare Foundation (ILCHF) and its grantees have deep experience in this work. ILCHF completed its first cohort of Children's Mental Health Initiative (CMHI 1.0) system of care grants in 2017. Last year ILCHF funded 5 out of 29 CMHI 2.0 applications for a second cohort of System of Care grants, which includes Illinois' first System of Care grant to support homeless children in Chicago with Primo Center for Women and Children as the lead grantee. ILCHF can provide technical assistance templates, timelines, and budget information, to inform this work.

THE FIRST 100 DAYS: Complete research to get an understanding of needs and service gaps. Determine the process for identifying participating communities. Determine process for identifying evaluator for project. We suggest three or more communities so that the cohort of participants is large enough to learn from one another throughout the process. The creation of a learning community among the CMHI 1.0 and 2.0 communities has been very helpful to the participating communities.

LONGER TERM IMPLEMENTATION: Fully engage and support the selected participants in planning, implementing and evaluating their System of Care. From a child health perspective, potential specific measurable outcome goals that address the development of effective service systems which positively impact the lives of children and families could include: (1) improvement in life domain functioning for children with and at-risk of serious emotional disturbances or other health issues, including school participation and academic success variables; (2) strengthened parenting practices and caregiver - child relationships; (3) early identification of children and youth for whom there is concern about possible mental and other health disorders; (4) reduction in unmet basic needs of families participating in the health service system; (5) reduction in caregiver related stress for parents/primary caregivers of children with health issues; (6) reduction in parental depression; increased capacity in the service system to provide families with evidence-based clinical interventions; (7) increased parent/caregiver/youth 'peer' provided services and leadership in the local system of care; (8) effective community use of data to inform operations and changes in the system, including sharing data between service provider systems; (9) an analyses of the costs and benefits of the project; (10) development of a well-prepared healthcare workforce and (11) measurable positive impact on the integration of service providers in the community.

POTENTIAL CHALLENGES: The greatest challenge may be finding a way to commit to this work for the period of time necessary. Having funded/facilitated numerous similar projects we have learned that this is hard, complex work that takes time. However, it is life-changing for the children, families and communities who participate.

A key element is to fund a planning year which allows stakeholders to take time out of their usual work to effectively plan for the implementation of their System of Care. Planning and implementing the change in work-flows that is required to fully operationalize an effective System of Care that eliminates current silos among providers is highly challenging but ultimately worth-while.

Lightfoot Transition Committee on Health and Human Services

Date: April 15, 2019

Name: Judith A. Cothran MD

Transition Committee: Health and Human Services

Note: I was one of the co-authors of the Lightfoot for Chicago Public Health Policy. As such, the goals outlined in this memo are also considered in that document.

Objective: Ensure all Chicagoans have access to integrated health services, especially where data show gaps exist.

Initiative: Optimize the use of Public Health Clinics and Create Free Medical Clinics to close the gaps in the public health system for the uninsured working poor, immigrants, and homeless residents in our city.

Chicago currently has dozens of Federally Qualified Community Health Centers, Public Health Clinics, and Free or Income Based Clinics where uninsured and Medicaid patients receive health care. However, many of Chicago's neighborhoods particularly on the south and west side lack access to medical services. Even in areas where clinics exist, there is little access to medical specialists and mental health services which are critical to integrated healthcare. This gap is even more striking for immigrants, the uninsured working poor, and homeless residents.

Additionally, many residents do not realize they qualify for Medicaid Insurance or due to red tape wait months to receive an insurance card. The delay in receiving insurance often means that patients cannot access primary health care services for chronic conditions like asthma, hypertension, diabetes, chronic obstructive pulmonary disease, and heart failure, or acute conditions such as upper respiratory infections, urinary tract infections, or early pregnancy.

The lack of access to affordable primary health care leads to over utilization of the city's Emergency Departments (ED) and Ambulance Service. Because they cannot afford to see a doctor, patients will often wait until their condition worsens and present in the Emergency Department for care. Emergency Room providers treat the acute condition but often lack an adequate referral base to send patients for follow-up and continuity care. The Emergency Departments, particularly in **Chicago's Safety-net Hospitals**, are stretched to the limit and the primary health needs of patients are not being met.

Emergency room treatment is also the most expensive care in the public health system. Therefore, finding practical solutions to increase access to primary care is not only better for the health of our residents, it's cost effective.

Existing Community Health Centers and Mental Health Clinics are doing a good job providing primary continuity care. However, many residents do not know how to access the clinics or cannot be seen without insurance.

In the first 100 days, I recommend the following:

1. Bring attention to the current state of healthcare for Chicago's underserved residents. Mayor Lightfoot, along with commissioners and members of this committee, should visit **Chicago's Safety-net Hospitals**.
2. Evaluate the current capacity of Chicago's Safety-net Hospitals to determine which patients are being seen in the ED that should be seen elsewhere, and evaluate the current capacity of health clinics in the community surrounding the hospital.
3. Look at ways to streamline the Medicaid Insurance application process, reduce the time to obtain insurance verification, and allow access to care for patients who have applied and are waiting for insurance cards.
4. Identify the **Free and Income-Based Health Centers** in the city and create a database on the city's website for public access.

Long term Investment:

1. The city should budget for additional **Public Health and Mental Health Clinics** in underserved neighborhoods and ensure access to primary health care in every neighborhood in the city.
2. The city shall ask each of the medical schools and hospital systems to make long-term financial pledges to support the creation and operation of **Free Medical Clinics**. The city will identify vacant or underutilized buildings or property in underserved communities to house the clinics. Trade unions and Community Workforce Development organizations will work with the city to identify residents to provide skilled and unskilled labor to build clinics or rehabilitate structures. Clinics will be staffed by medical students, medical residents, fellows, nurses, and attending physicians.
3. Access to care should extend beyond typical work hours to accommodate the uninsured working poor. Because Free Clinics are staffed by volunteer medical students, residents, fellows, nurses, and attending physicians the clinic hours include evenings and weekends, thus providing a convenient alternative to the Emergency Department.
4. Televised Public Service Messages to provide the public with information about when to use the Emergency Department and Ambulance Service, and how to access healthcare in their community.

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MEMORANDUM

TO: Mayor-Elect Lori Lightfoot

FROM: Juan Morado, Jr.

DATE: April 15, 2019

SUBJECT: Health and Human Services Recommendations

I am honored for the opportunity to serve on the Health and Human Services Transition Committee and to submit this memorandum in furtherance of supporting our City and ensuring a Better Chicago Together.

While there are many issues that affect our city this memo will focus on increasing access to care that is both culturally sensitive and impactful to the entire city. Since the passage of the Affordable Care Act, the healthcare delivery system in our city like the rest of the country has undergone a fundamental shift. There is now an increased emphasis on preventive care although there are too many residents in our city who are still utilizing emergency care as their primary means of interacting with healthcare professions. Additionally, the numerous consolidations of various health care systems in our region has also impacted access to care for our city's most vulnerable patients. A multilingual healthcare literacy campaign would be one of the most impactful actions the Lightfoot administration could take to improve access to care in the short term.

A healthcare literacy campaign could have several benefits for the diverse neighborhoods in our city. Through initiatives like the data driven Healthy Chicago 2.0, the Department of Public Health has already identified those areas of the city that are underserved and lack access to care. We also have data from numerous social service and federally qualified health clinics that are already on the front lines in our neighborhoods providing care. The Lightfoot Administration could take this information and convene various stakeholders to begin a healthcare literacy campaign that could achieve several goals.

First and foremost, this campaign could be used to increase enrollment in insurance programs for the under and uninsured populations in our city. With the ongoing changes in policy at the state level and a pending bill to allow undocumented immigrants to enroll in Medicaid, a healthcare literacy program could play a crucial role in producing better health outcomes. The Cook County Health and Hospital System has done an excellent job of enrolling residents through their CountyCare plan and through other partnerships there is an opportunity to capitalize on that progress.

Secondly, existing data shows that there are number of chronic healthcare conditions that lead to emergency room visits that could be curbed with an increased emphasis on preventive care. Condition like diabetes which is highly prevalent in communities of color, is entirely preventable. That is why it is crucial that any healthcare literacy program be multilingual, to be inclusive of those residents who likely need assistance the most and don't know how to access it.

There are many healthcare disparity issues that our residents face every day, and we can have an immediate impact by using the tools we have available. In the long term we can seek to develop partnerships and use technology to leverage the city's resources and reach a wider audience. We should not forget that our city is home to several world class healthcare systems that currently provide care to our residents and we have the ability to transform the role the City has played in the healthcare of those individuals. An example of this type of collaboration can be seen in the Illinois Medical District where institutions like Rush University Health System is working with the Medical District, the City, and community partners to leverage their resources to improve the health and economic well-being of the communities where they serve. I am excited for the chance to help our city move forward and I am committed to working with Administration to improve health outcomes and access to care for all Chicagoans.

AIDS FOUNDATION OF CHICAGO

To: **Mayor-Elect Lori Lightfoot**
From: **John Peller, President & CEO, AIDS Foundation of Chicago**
Date: **April 15, 2019**
Re: **Recommendations for Health & Human Services Transition Committee**

The AIDS Foundation of Chicago congratulates you on your historic victory and appreciates the opportunity to participate in the transition process. These recommendations fit under the transition objective, "Ensure all Chicagoans have access to integrated health services, especially where data show gaps exist."

(a) What is happening today that we need to continue:

- *Chicago Department of Public Health (CDPH) new HIV service portfolio:* Since 2017, CDPH has worked to transform its portfolio of HIV prevention, health care, supportive services and housing grants. The goal of their new HIV service portfolio is to focus on the highest-impacted populations and better align services for the most vulnerable and HIV-positive populations. Some services started March 1, 2019 and others will begin September 1, 2019. AFC supports the smooth and thoughtful transition to the new funding portfolio and looks forward to seeing it fully implemented.
- *Flexible Housing Pool (FHP):* The FHP is a groundbreaking partnership that will improve the lives and health of highly vulnerable homeless individuals and save money for city systems. AFC's subsidiary, the Center for Housing and Health, serves as the FHP administrator by using flexible city funds to pay rents and services for people experiencing homelessness who are living with serious health conditions and are also frequent utilizers of Cook County Health and the justice system. Cook County government, hospitals, foundations and other stakeholders are making or discussing investments in the FHP that will dramatically increase the number of people housed from the current projected 75 people in year 1.
- *Health in All Policies*. AFC fully supports Healthy Chicago 2.0, which aims to formalize a "Health in All Policies" approach for the City of Chicago government, ensuring every city agency approaches its work using a health equity lens. We urge Mayor-Elect Lightfoot to champion this critical plan.
- *Undoing Racism:* CDPH has launched an ambitious effort to improve racial equity in Chicago, starting with its employees and delegate agencies. The Undoing Racism training, designed to analyze the structures of power and privilege that hinder social equity, should be expanded; racial disparities are at the heart of the health and public health challenges Chicago faces.

(b) What we need to implement immediately; or within the next year;

- *Fully embrace and implement Chicago and Illinois' Getting to Zero plan:* As a candidate, Mayor-Elect Lightfoot expressed her support for "efforts to effectively eliminate new HIV infections." The plan, a public-private partnership led by CDPH, AFC and the Illinois Department of Public Health, has engaged hundreds of stakeholders city- and state-wide and aims to end the HIV epidemic in the state by 2030. We urge the new administration to review the plan, embrace its recommendations and direct all city departments to assist with implementation. Learn more about gtzillinois.hiv.
- *By October 1, 2019, launch a city-wide initiative to enroll every eligible Chicagoan in Medicaid or Marketplace Coverage:* Health insurance coverage is the foundation of good health for Chicago, yet 9.8% of Chicagoans are uninsured.[1] Chicago should fund community-based organizations to place trained navigators at high-traffic sites, such as DFSS offices and city colleges, that have large numbers of visitors likely to be uninsured.

[1] Chicago Health Atlas, People with No Health Insurance Coverage 2017, https://www.chicagohealthatlas.org/indicators/no-health-insurance, accessed 4/15/19.

- *Overhaul the CDPH contracting and payment process and improve the DFSS process.* CDPH's contracting process is severely inefficient; it can take six months to get contracts approved and an additional three months before vouchers are paid. DFSS, while far better, has burdensome paperwork requirements. Chicago cannot expect a healthier city without fiscally sound delegate agencies, which struggle with cash flow and sometimes can't make payroll. The City should engage outside consultants to review the contracting process and develop and implement a plan for improvement that includes the all key agencies, including the Comptroller.
- *Improve comprehensive sexual health education programs in all Chicago public schools.* CPS's already-strong sex ed program can be improved. CPS should ensure all schools have equal resources to implement sex ed programs; City Clerk Anna Valencia's "Chicago's New Deal for ALL Women & Girls" report contains strong recommendations.
- *Reduce sexually transmitted infections and support stopping the opioid epidemic:* As the nation reaches record numbers of STI cases, Chicago should expand the effective "brown bag" STI testing and treatment program to more CPS high schools. Chicago should also launch a joint City/County taskforce to develop a comprehensive strategy to address STIs and opioid use.
- *Implement a real estate transfer tax for properties worth over $1 million.* AFC strongly supports the Bring Chicago Home campaign, which would dramatically expand resources to address homelessness and increase access to affordable housing.
- *Expand workforce development opportunities for low-income LGBT Chicagoans, with an emphasis on people most vulnerable to HIV and people who are transgender:* An individual's health improves as their income increases. Because LGBTQ people face high rates of poverty[2] and LGBTQ Chicagoans face health challenges at higher rates than their non-LGBT peers,[3] Chicago should focus job training and workforce development efforts on LGBTQ Chicagoans, with a focus on youth of color, justice-involved populations and trans populations.

(c) What we can plan for longer-term implementation.

- *Implement LGBTQ cultural competency in all aspects of city government, including sister agencies.* City employees and delegate agencies must have comprehensive LGBTQ cultural competency training to meet the specialized needs of the population, with a focus on services for seniors and youth.
- *Address the needs of LGBTQ older adults (including people with HIV) in all aspects of their lives.* LBGTQ adults over 55 face particular challenges as they age, including potentially having to go back into the closet when they move into assisted living facilities, and the social service and health care systems are not prepared for increasing numbers of older adults living with HIV.
- *Reduce drug overdoses, Hepatitis C and other negative health outcomes*. Chicago can make real strides by expanding sterile syringe programs and implementing safer consumption spaces, which are facilities where people can safely use drugs with medical supervision.
- *Develop and implement a citywide plan to cure Hepatitis C and reduce rates of Hepatitis A and B* through widespread testing, treatment and vaccination, built on the infrastructure of CDPH's HIV/STI program.
- *Develop health insurance coverage for undocumented and other ineligible populations* with Cook County and the state. Undocumented people are not eligible for Medicaid and other health programs, which means they cannot access comprehensive health care, including specialists.

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[2] National LGBTQ Task Force, New Report on LGBTQ Poverty Shows Need for More Resources and Research, http://www.thetaskforce.org/povertyreport/, 5/1/18, accessed 4/15/19.

[3] CDPH, Lesbian, Gay, Bisexual and Transgender Health, March 2018, https://www.cityofchicago.org/content/dam/city/depts/cdph/LGBTQHealth/CDPH_2017LGBT_Report_r6a.pdf, accessed 4/15/19.

TO: Mayor Elect Lori Lightfoot
FROM: José Rico, United Way of Metro Chicago
RE: Defining and operationalizing the optimal role for City departments, including CDPH and DFSS

Heal Our City: Leveraging critical lessons from NGO efforts to stop gun violence and meet the basic needs of the most marginalized by building a human service infrastructure in our neighborhoods so they can be economically sustainable.

Background**:**
We in the human service sector see how structural violence, poverty and disinvestment, inflict pain that rips through families and communities and know this is a manifestation of racial inequity. Chicagoans in the south and west sides persistently experience segregation, disinvestment and neglect due to city policies and practices. This has **severed critical relationships and entryways into basic services and opportunities for families, blunting social mobility and pushing families out of Chicago**. Therefore, our solution should place neighborhood residents at the center of the transformative process. We should measure our progress from the experience of a single mother in Roseland, a CPS student with undocumented parents in Back of the Yards, and a returning citizen in Austin. oth, DFSS and DPH are concluding important initiatives and recommendations, including over $200M that will need to be reallocated. We have a combined body of knowledge and available resources to **reimagine** how we can operate.

Proposal:
The role of DFSS, CDPH, and others should be of ASSURANCE, ASSESSMENT and POLICY DEVELOPMENT focusing on integrating funding into neighborhood-based initiatives that will promote social and economic mobility for households (families). There's a need to orient Cabinet agencies toward identifying and implementing shared objectives at the neighborhood level. In order to start rebuilding the human service infrastructure, Cabinet-level resources should be used for community engagement, system mapping and network design, to create internal systems that will enable CDPH, DFSS and other agencies to implement shared goals. The **first 100 days of the Lightfoot administration** should focus on creating and implementing a process of community ownership and design of integrated services to be deployed in our neighborhoods. Using a **Truth and Healing** process, we must proactively and unapologetically confront the systemic inequities of racism, corruption and misogyny that allow structural violence to persist in Chicago. We do this by **repairing and connecting relationships** in our neighborhoods using **Better Together conversations,** creating local teams to engage neighbors with local *promotoras*, first responders, social workers, educators, city/county workers. Implementing robust neighborhood convenings will allow the City to reconnect with residents, creating local authority, mapping a system of needs and assets, and leading to multi-sector partnerships on the ground.

In addition to making Cabinet level changes necessary to rebuild our human service infrastructure, there needs to be a shared, community-facing outcome that will directly benefit and be co-designed by neighborhood stakeholders. One long-term outcome can be the **opening of ChiHeal and Wellness Centers.** These Centers can be opened at various locations (schools, park districts, CBOs, health clinics, neighborhood chambers of commerce, businesses, etc.) and services will be based on the needs, assets, and aspirations of the residents. We know that there are many buildings that can be refurbished or retrofitted to be anchors in our neighborhoods. They will be charged with improving the outcomes of that community to live healthier, graduate more students, increase jobs and household wages , reduce violence and bring people together. They can cover the service deserts that currently exist in our City, providing long-term funding and resources for neighborhoods that are on the road to integrating services and need targeted assistance. They will provide or offer referrals to integrated human-services such as professional mental health services, job and entrepreneur training, wellness counseling, and after school programs that individuals and families can access that are free and culturally-responsive. These Centers can be the visible embodiment of the Administration's values in our city. Additionally, they will be necessary to create a network of human services and information that will provide the administration with needed feedback to measure its' progress in achieving racial equity in the allocation of resources, connecting individuals and providing pathways for families.

Austin Coming Together is an example where CDCs, CBOs and others have gone through a long planning and capacity building process to bring various stakeholders together to launch an initiative that leverages neighborhood assets and addresses their needs. These innovative initiatives braid together various human services, and require coordination with economic development, housing, street outreach or small business efforts. Many of these initiatives have been supported by intermediaries and private funders and have had very little City involvement.

The Lightfoot administration can facilitate a clear direction and goals for this sector and help coordinate and integrate of all the stakeholders involved to create a human service infrastructure that will allow community residents to lead sustainable neighborhood initiatives that will directly impact them.

April 15, 2019

Name: Dr. Jay Shannon, CEO, Cook County Health

Committee: Health and Human Services

Prompt: Ensure all Chicagoans have access to integrated health services, especially where data show gaps exist

Cook County Health (CCH) recommends further expansion of Medication Assisted Treatment (MAT) to fight the opioid epidemic. Stakeholders need to increase capacity of MAT services to ensure that all communities have equal access.

How the new administration can infuse the values of equity, transparency, accountability, diversity and inclusion.

Health inequities are at the core of many of the health conditions minority communities experience. From housing and food instability to basic access to care, minority communities fare far worse than their white counterparts. In its 2017 report, the Chicago Urban League discusses the impact the opioid epidemic has had on the African American community. Specifically, the report states:

- Chicago has experienced an extreme increase in fatal opioid overdoses in just one year– an increase of nearly 75%.
- Black people make up approximately 32% of the population in Chicago but account for nearly half (48.4%) of all opioid deaths.
- In 2016, the African American death rate from opioids in Chicago was 56% higher than the white death rate in Chicago (39.3 vs 25.1 per 100,000).
- Compared to U.S. data from 2015, which is the most currently available data from the CDC, in Chicago the African American death rate in 2016 was nearly four times higher than the national average in 2015 (39.3 vs 10.4 per 100,000).
- The neighborhoods with the highest overdose death rate from fentanyl include East and West Garfield Park, North Lawndale, Austin, Humboldt Park, Fuller Park and Englewood – all racially concentrated areas of poverty. [1]

[1] https://www.thechicagourbanleague.org/cms/lib/IL07000264/Centricity/Domain/1/Whitewashed%20AA%20Opioid%20Crisis%2011-15-17_EMBARGOED_%20FINAL.pdf

What is happening today that we need to keep?

In 2016, Chicago and Cook County came together and created a task force on heroin. The Task Force issued its report on October 6, 2016. Significant progress has been made since the release of the report which included dozens of recommendations to address the opioid epidemic that continues to plague our communities. Several recommendations specifically addressed the need for education and funding to support Medication Assisted Treatment (MAT) efforts.

Current Cook County Health Initiatives include:

CCH has implemented a new opioid screening tool, which includes screening for fentanyl and other synthetic opioids. Sites for testing include Stroger Emergency Department and trauma, Pain Clinic, the Ruth M. Rothstein CORE Center, CCH primary care centers and Correctional Health Services.

CCH currently offers MAT services in its facilities located in Chicago. These include 8 primary care centers, the Stroger emergency room and correctional health services at Cook County Jail. In 2018 alone, CCH logged 5,000 visits with clinicians and/or recovery coaches related to MAT.

CCH has dedicated recovery coaches in the Stroger Emergency Department to ensure patients are linked to appropriate community-based services, including MAT.

CCH created and funded the development of the Behavioral Health Consortium which includes behavioral health and substance use disorder services providers with a single point of entry for specialty behavioral health services that span the continuum of care for CountyCare[2] members and individuals served by CCH community clinics.

CCH's Departments of OB-GYN and Family and Community Medicine recently received a Health Resources and Services Administration (HRSA) grant to improve systems of comprehensive care, including MAT, for opioid use disorder during the perinatal period.

CCH has applied for a Centers for Disease Control and Prevention (CDC) grant with Chicago Department of Public Health and Cook County Department of Public Health. Among other things, if funded, this grant would support the implementation of a technology-enabled tool to re-engage patients who are out of care when they appear in any of our clinical settings.

CCH Department of Family and Community Medicine will launch MAT in a family medicine resident clinic in July 2019.

We offer buprenorphine waiver trainings for CCH clinicians as well as partnering Federally Qualified Health Centers (FQHCs) and external collaborators to help build regional capacity.

CCH is participating in a city-wide hospital learning collaborative on buprenorphine and naloxone access in emergency department and inpatient settings. The collaborative launches on April 15, 2019.

CCH will be launching weekly recovery support groups in one ambulatory clinic this Spring, with plans to expand to at least 3 sites by end of 2019.

CCH continues to conduct important research to inform initiatives to address the opioid epidemic.

[2] CountyCare is a Medicaid managed care plan owned and operated by Cook County Health.

Current CCH Justice-Involved Initiatives:

In its role as the provider of healthcare at Cook County Jail, Cook County Health has trained thousands of individuals on the use of naloxone and distributed kits to more than 3,000 detainees upon discharge. CCH Correctional Health provides medications for opioid use disorder (all three US Food and Drug Administration (FDA) approved medications), which is gold standard but rare in U.S. correctional facilities) and care coordination. In 2018, slightly over 700 patients received these services, and approximately 150 patients receive the medication plus coordination each month. Upon release, CCH refers MAT patients to our own outpatient centers and other providers.

CCH social workers screen for substance use and mental health disorders in the Cook County Bond Court and offer linkages to care including MAT at CCH.

CCH recently received a Comprehensive Opioid Abuse Program (COAP) grant to support screening mental health and opioid use disorders for those clients receiving probation services. If positive, clients will be linked to appropriate services. Implementation planning is underway and anticipate screening and linkages to start in May.

The COAP grant also requires the screening of the CCH – opioid use disorder (OUD) probation departments' policies and procedures by stakeholders. Members from the probation department will be joining the CCH OUD Stakeholder Committee to support this work.

CCH is working with the Circuit Court of Cook County's Adult Probation Department to improve access to evidence-based care, including MAT, for individuals on probation.

CCH has applied for a grant from the Substance Abuse and Mental Health Services (SAMHSA) to break down barriers to entry and care transitions for patients referred for MAT from jail, inpatient and ED. Work will start in July if we are funded.

What we need to implement in the next 100 days

Reconvene/reconstitute the Chicago-Cook County Task Force on Heroin to report progress on recommendations and adjust/update MAT-specific recommendations based on progress that has been made. Consider establishing the task force as a permanent entity until the epidemic has been adequately addressed.

MAT capacity is an issue in Chicago. Identify additional funding streams to increase MAT capacity. Inventory all MAT providers in the City of Chicago and number of individuals currently in MAT. This inventory should be made public for programs accepting new patients and used to identify where additional resources should be focused. Consider engaging a research body to fully understand what the data is signaling and how to better deploy resources.

Fund public education campaign around MAT that includes information about addiction and available resources. Work with Chicago's civic, religious and social service partners to ensure that the scale of the epidemic is fully understood. CCH's latest campaign "Making an Impact" will address addiction and provide link to available resources. Limited financial resources will limit the reach of this campaign. Perhaps the City will provide additional space on City digital billboards as a public service. Campaign will go live in May, 2019.

In Cook County and Chicago, most opioid deaths are from the street drugs heroin and fentanyl. Engage law enforcement on appropriate strategies to prevent the trafficking of the drug and to alert hospital emergency rooms when identified.

Training at-risk populations and their networks on the use of naloxone has certainly saved lives. First responders are on the front line of this epidemic and many have been trained in identifying and responding to an opioid overdose using naloxone. Develop a concrete plan to ensure that all first responders are both trained and properly equipped with naloxone should occur.

Begin advocacy effort to encourage Narcotics Anonymous (NA) or other support groups to allow full participation by MAT patients. CCH has learned that while individuals undergoing MAT are welcome to attend NA support groups, they are not always allowed to fully participate in meetings as NA is a 'program of complete abstinence.'[3] Individuals are encouraged and sometimes required to remain observers in the meetings.

What we can plan for longer-term implementation

See Chicago-Cook County Task Force recommendations for those recommendations yet-to-be-implemented.

Continue to further develop diversion and deflection efforts with the Chicago Police Department for those with serious mental illness or who have substance use disorder (SUD).

Explore the impact of policy changes to consider low level opioid possession a misdemeanor rather than a felony.

Institute mandatory first-responder training and ensure that all first responders have ready access to naloxone.

Partner with the Chicago Recovery Alliance to extend their capacity as a street-level resource.

What challenges we might encounter in executing initiative

Limited resources (financial, human, capacity)

Competing priorities

Public awareness/acceptance of scale of problem

Stigma of Opioid Use Disorder continues

[3] https://www.na.org/admin/include/spaw2/uploads/pdf/pr/2306_NA_PRMAT_1021.pdf

Transition Committee Memo: Healthy Chicago 2025

Name: Jen Vidis, Chicago Department of Public Health
Transition Committee: Public Health & Human Services

Potential initiative: Launch and support implementation of Healthy Chicago 2025, a five-year action plan for the local public health system to transform policies, systems, and environments that address the root causes of health, with a focus on racial equity.

How the new administration can infuse the values of equity, transparency, accountability, diversity and inclusion, and transformation in this initiative

The life expectancy gap between neighborhoods experiencing high and low economic hardship has increased by 60% since 2012, to a current gap of eight years. This stark reality prompted CDPH and more than 130 local partners to create Healthy Chicago 2.0, a four-year plan with a vision of strong communities and collaborative stakeholders, where all residents enjoy equitable access to resources, opportunities, and environments that maximize their health and well-being.

Since its launch in 2016, the plan has helped guide community organizations, foundations, public agencies, and other institutions to take collective action on more than 200 strategies in several areas, including: root causes of health (housing, built environment, economic development, and education), access to services, behavioral health, child and adolescent health, chronic and infectious disease, and violence prevention. We committed to transparency and accountability by reporting publicly on more than 160 measures of health equity on the Chicago Health Atlas, an interactive website where you can explore data by race/ethnicity and analyze health at the community level. Now that the four-year timeline of Healthy Chicago 2.0 is coming to a close, CDPH is engaging a wide range of partners and community members to do another assessment of health challenges and priorities in Chicago. Equity will remain our North Star as we jointly develop transformative initiatives to serve the residents and neighborhoods with the greatest need.

What is happening today that we need to keep

As a framework for the city, Healthy Chicago 2.0 has strengthened the role of CDPH and the local public health system in leading collective action to promote health equity.

- **Data**. We regularly produce reports on the health status of Chicago residents – recently on LGBT health and opioids – to highlight inequities and then inspire and inform action.
- **Cross-sector coalitions.** We convene or support partners across sectors – from hospitals working together to benefit their communities (West Side United, Alliance for Health Equity), to equitable transit-oriented development (Elevated Chicago).
- **Health in all policies.** We brought City departments and sister agencies together to help ensure health impact and equity are considered as part of every department's work.

- **Coordinating health services.** With the expansion of health insurance, CDPH's need to provide direct services has diminished. But there is an important role for CDPH to monitor and support the overall system – connecting patients to the right care, determining the city's most pressing health needs, and filling gaps through targeted funding.
- **Anti-racism.** CDPH is leading transformation around racial equity. We joined the Government Alliance on Race & Equity, trained more than 400 staff members and community partners, hosted a symposium on structural racism and health, and plan to hire a Chief Equity Officer in 2019.
- **Seed grants.** CDPH funds local, community-led initiatives that are responsive to each neighborhood's unique character, context, and challenges. Such funding helps advance health equity by building community power and capacity.

What we need to implement in the next 100 days

We will share findings from our community health assessment in May, including priority issues identified by community members. Within the first 100 days, CDPH will work with the Lightfoot administration to lead an inclusive process to finalize and publicly launch Healthy Chicago 2025, a plan for action in these areas. Based on input so far, we expect that this plan will focus on strategies to improve health outcomes (chronic disease, maternal and infant health, behavioral health) by channeling the collective power of the local public health system to address the root causes – including social/institutional inequities and neighborhood conditions. Treating a health problem on the back end is not as effective as creating strong community conditions to prevent problems on the front end. Healthy Chicago 2025 will more clearly define the local public health system's role in tackling these issues through advocacy, strategic partnerships, community capacity building, and civic engagement.

What we can plan for longer-term implementation

Within the first 100 days, we will launch Healthy Chicago 2025 as a new framework for the city; then the work of executing on the plan will span the following years. Implementation will require ongoing championing from the Mayor's office and CDPH, along with resource alignment as needed to carry out strategies outlined in the plan.

What challenges we might encounter in executing on this initiative

The proposal to finalize the Healthy Chicago 2025 plan in the first 100 days is ambitious. We may encounter challenges in trying to balance this timeline against our desire for a robust, inclusive engagement process. By moving 'upstream,' this plan will also position the local public health system to take a more active role in issues that are beyond our traditional areas of authority. It will be important to clearly delineate with City partners and external stakeholders how public health can bring added value to work on topics like affordable housing, food systems, equitable development, and environmental justice.

Lori Lightfoot | BETTER TOGETHER CHICAGO

Transition Committee Memo: Healthy Families

Name: Jen Vidis, Chicago Department of Public Health
Transition Committee: Public Health & Human Services

Potential initiative: Address maternal and child health inequities through expanded paid parental leave and implementation of an evidence-based universal nurse home visit model.

How the new administration can infuse the values of equity, transparency, accountability, diversity and inclusion, and transformation in this initiative

A recent report from the Illinois Department of Public Health highlights the racial inequities in maternal and infant health: in our state, black women are six times as likely to die of a pregnancy-related condition as white women. CDPH data reveal that infant mortality, an important indicator of the health of communities, has increased 21% in high hardship areas since 2013 and that black babies are dying at a rate three times higher than white babies. The weeks following birth are critical for babies and mothers alike, affecting early learning, mental health, and many other outcomes. This initiative proposes transformational policy and system approaches to address these pressing challenges by ensuring families have the support they need in first weeks of a newborn's arrival.

1. **Extend Paid Parental Leave.** Doing so will improve family health, boost employee recruitment and retention, and position the City as a leader on this issue.

2. **Implement a Universal Nurse Home Visit Program.** After nine months of research and engagement with diverse stakeholders across sectors and communities, CDPH has identified a model, Family Connects International, that uses registered nurse home visits and a process for community-driven alignment to create a coordinated referral system that will ensure no Chicago family falls through the cracks.

What is happening today that we need to keep

The City has a paid parental leave benefit that the outgoing administration implemented in 2011: two weeks of leave for fathers (and mothers who adopt), four weeks for mothers with vaginal births, and six weeks for mothers with C-section. This was an important step for City of Chicago employees – but we can do more, both for City employees and other Chicagoans who lack such a benefit. In fact, the 2017-18 Healthy Chicago Survey, Jr., revealed that 4 in 10 employed parents reported having no paid sick leave of any kind.

Further, the City has an extensive array of programs and services for new families delivered by committed providers who are using evidence-based practices and achieving good outcomes. Yet, we know that many families who are intended to receive these services are never reached, while others receive duplicate services. Lacking a coordinated system, we are missing opportunities to reach families at greatest risk and more efficiently deploy our valuable resources. CDPH has been piloting work across hospitals to identify mechanisms of better delivering and coordinating needed services.

What we need to implement in the next 100 days

Extend Paid Parental Leave for City Employees. In the next 100 days, the Lightfoot administration could introduce and pass an ordinance expanding paid family leave for City employees to twelve weeks (including adoptive parents, mothers, fathers, and grandparents). A similar proposal was evaluated and found to be feasible by the City of Chicago's Office of Budget and Management and Department of Human Resources. This first step will also provide leverage for an effort to require that comparable leave be offered by all employers in Chicago.

Implement a Universal Nurse Home Visit Pilot: In partnership with regional, cross-sector community accountability boards, the Family Connects system will:

- Conduct home visits to screen all mothers and newborns for health, safety, and emotional well-being within three-to-five weeks of birth.
- Respond immediately with brief interventions, education, and support—for instance, on breastfeeding or managing crying.
- Respond with longer-term solutions through connections to evidence-based services that address the family's specific issues.
- Improve agency coordination to provide a seamless experience for participants, including follow-up, and ensure that the system is responsive and accountable to the needs of families.
- Identify gaps in and barriers to service delivery to improve resource access and allocation, and to inform policy changes.

CDPH is preparing to launch and evaluate a pilot Implementation of Family Connects. In the next 100 days, we will complete recruitment of 3-5 pilot hospitals serving high needs communities, using criteria developed by a consulting taskforce of diverse stakeholders. We also expect to release an RFP for community organizations that will establish and support 2 of 6 planned regional community alignment boards. To ensure that inclusive engagement remains a hallmark of our approach, we will convene a citywide Advisory Board to inform the pilot and plan for scaling.

What we can plan for longer-term implementation

Once we have results and learnings from a successful pilot, CDPH will seek to implement Family Connects at scale with all 19 Chicago birthing hospitals within five years. The Lightfoot administration could also convene a task force of business organizations, employers, labor and family advocacy organizations, elected officials and working family representatives, to produce recommendations for ensuring all working Chicagoans have the ability to take paid parental leave. Research shows that the longer-term solutions to maternal and infant health inequities are complex and include addressing root causes such as poverty, employment, housing, availability of childcare, and quality of education.

What challenges we might encounter in executing on this initiative

The model has extensive support from the community and the state; however, mayoral support may be needed to ensure full hospital participation and adequate funding for scaling. The expansion of paid parental leave for City employees will require approval of the City Council. Identifying the companion mechanism for expansion to all employers, while critically important, will require broad based support from the private sector, the City Council and possibly the state legislature.

Transition Committee Memo: Healthy Food System

Name: Jen Vidis, Chicago Department of Public Health
Transition Committee: Public Health & Human Services

Potential initiative: Develop a comprehensive food plan for Chicago that will expand significantly on previous planning efforts and focus on racial equity to support community health and wealth.

How the new administration can infuse the values of equity, transparency, accountability, diversity and inclusion, and transformation in this initiative

Food choices are shaped by our environments. Affordable, accessible and healthy food is not equitably distributed across Chicago. In addition, approximately one in three Chicago residents is food insecure, with significant disparities among communities of color. Policy, planning, and related city investments are fundamental tools that could be used to transform the local food system to advance health equity along with social, economic, and environmental justice.

The health sector and community coalitions recognize the importance of food access to community health and well-being, and have made this issue a priority in their hospital Community Health Needs Assessments (required by the Affordable Care Act) and resident-led quality of life plans. A coordinated food plan would complement these efforts and also allow the City to drive the alignment of resources and development of additional policy solutions.

What is happening today that we need to keep

- **Good Food Purchasing Program:** Launched by resolution in 2017, Chicago's Good Food Purchasing Program (GFPP) leverages approximately $200 million in annual governmental procurement in support of five core values: local food economies, fair labor, environmental sustainability, nutrition and animal welfare. Chicago's Good Food Task Force, led by CDPH and the Chicago Food Policy Action Council (CFPAC), serves as an operational example of existing interagency collaboration to support an equitable food system. Ongoing efforts should be supported and further prioritized – by providing funding for operational expenses (e.g. baseline and annual assessments, data infrastructure, etc.), developing complementary policy solutions and pathways to support participation of small, local food entrepreneurs, and ensuring that City departments and sister agencies move towards higher ratings across GFPP standards.
- **A Recipe for Healthy Places:** Launched in 2013 as an outgrowth of Healthy Chicago, A Recipe for Healthy Places has provided a roadmap for food planning progress to date. Its related food access strategies could be leveraged, updated and resourced to, as appropriate.
- **Food access and insecurity data**: Additional food system indicators from the Healthy Chicago Survey will be made available as part of CDPH's community health assessment this spring. CDPH will share this information with experts, other departments, and community groups to help inform Healthy Chicago 2025 priorities.

- **Supportive partnerships:** Collaborative healthcare partnerships such as West Side United and the Alliance for Health Equity are prioritizing food insecurity screening and response as a strategy within their community benefit plans. Neighborhood coalitions, supported by organizations like LISC, CMAP, and United Way, have also prioritized increasing food access and developing healthy food enterprises as part of quality of life or related planning efforts. An aligned, coordinated City response would advance these community-driven strategies.

What we need to implement in the next 100 days

The Lightfoot administration could issue a call to action to develop a comprehensive food system plan for Chicago. This could be achieved through adoption of a "Healthy Food System" resolution and/or through the convening of an interagency (plus expert stakeholder) working group, as part of the development of Healthy Chicago 2025, the city's action plan to advance health equity led by CDPH. The process of creating a comprehensive food system plan will allow specific policy options and related planning efforts to be developed systematically, build on each other and address local challenges within the food environment.

As an immediate first step to show our City's commitment to this issue, the Lightfoot administration could also take executive action to require that City departments abide by the Good Food Purchasing Policy, which is currently voluntary, and make the City's commitment to equity explicit within it.

What we can plan for longer-term implementation

We expect that, with appropriate staffing and resources, a comprehensive food system plan for the City could be developed within 12 months. The plan would include:

- An assessment of current gaps and opportunities to increase equity in our food system.
- Policy recommendations to address priority issues, such as increasing access to and affordability of healthy food; improving the economic vitality of local food production; and strengthening the food safety net.
- Strategies for working with the health sector and community partners to align resources and coordinate efforts in support of local priorities.
- Development of an operational and accountability structure that includes and is driven by community stakeholders and priorities.

Following the adoption of a food system plan, strong leadership from the mayor's office and CDPH will be required to assure successful implementation – by aligning City resources, planning and funding decisions, maintaining accountability for plan execution among other City agencies, and conducting an assessment of impact.

What challenges we might encounter in executing on this initiative

Many elements of the food system exist outside of the traditional areas of authority for public health. This proposal will require development of additional capacity within City government to assess, develop and assure equitable food policy and planning efforts – as well as support for ongoing coordination across multiple departments and sister agencies.

Transition Committee Memo: Opioids

Name: Jen Vidis, Chicago Department of Public Health
Transition Committee: Public Health & Human Services

Potential initiative: Take aggressive, comprehensive action to confront the opioid epidemic.

How the new administration can infuse the values of equity, transparency, accountability, diversity and inclusion, and transformation in this initiative

Stopping the opioid epidemic is about equity. The epidemic claimed 796 lives in Chicago in 2017—more than homicide. CFD responded to more than 7,500 additional non-fatal opioid overdoses. The crisis is devastating families, straining the criminal justice system, and damaging the economic prospects of the to the communities most in need of development. The media has made much of the rise of prescription opioid use among young suburban and rural whites, but the story in Chicago is one of rising deaths due to illicit opioids. Heroin, often laced with fentanyl, is linked to more than 90% of Chicago's fatal overdoses—with a disproportionate effect on older black men. Overdoses are concentrated on the west side, and most of the victims live on the south or west side.

This initiative is also about transformation. Instead of addressing opioids piecemeal through one-off projects, we must change the way our whole system handles the issue. That requires institutionalized collaboration with partners including law enforcement, EMS, hospitals, health clinics, and community-based prevention, treatment, and recovery programs. Building those bridges—and identifying and filling gaps in the system through targeted funding—constitute the best role for a local health department.

What is happening today that we need to keep

Since 2015, the City has taken a series of important steps, many based on recommendations of the Heroin Task Force that was convened by the City and Cook County. Recent investments have been in:

- Medication-assisted treatment (MAT), an evidence-based approach that combines medication with behavioral health services to combat opioid use disorder. Overall, patients do much better with MAT than with basic detox programs, but special training for medical providers is required.
- Recovery homes, which are not funded by Medicaid, but help patients reestablish their lives.
- Community distribution of naloxone, which reverse overdoses on the spot.
- Funding for people leaving Cook County jail to get addiction treatment and naloxone.
- Peer health educators who conduct outreach, disseminate overdose prevention messaging, distribute naloxone, and provide information on treatment resources to fellow community members. This is supplemented by OvercomeOpioids.org.
- Education of medical providers on addiction treatment and safe prescribing through trainings and a learning collaborative (though funding for part of this work has run out).
- A pharmaceutical representative license, which is not a CDPH priority but has freed up resources for addiction treatment.

- Extensive data collection and analysis, including published epidemiology briefs. We are working toward an early warning system to respond to overdose outbreaks.

What we need to implement in the next 100 days

Numerous pieces could be announced quickly as part of a set of opioid priorities, though none of them could be implemented until next year when the new budget passes. See next section.

What we can plan for longer-term implementation

- Ensure hospitals and their emergency departments create opioid overdose response programs. Such a program would (1) be able to start patients on medication-assisted treatment right away after an overdose, (2) provide them with naloxone kits when they leave, and (3) make a warm hand-off to ongoing community-based treatment. This could entail providing City funding to hospitals, or at least funding ongoing technical assistance to meet the benchmarks.
- Expand access to naloxone, an overdose reversal drug, in community settings, particularly on the west side. Today, much of the distribution is done through syringe exchange programs, and many heroin users snort rather than inject.
- Ensure increased and sustainable funding for community health educators who engage at-risk residents through overdose education and links to treatment. This approach has been effective on the south side. We funded a one-year pilot program from a Pfizer donation, then secured additional funds from Blue Cross Blue Shield, but there is no sustained or City funding stream. Programs like this should be widely expanded to new community partners in high-need areas.
- Explore new ways to deliver medication-assisted treatment, including at federally qualified health centers, mental health clinics, and mobile vans.
- Enhance first responder capacity by arming more officers with naloxone; expanding a successful pilot program that follows up with patients days after CFD reverses an overdose; and expanding CPD's west side diversion pilot, which allows people arrested for low-level, non-violent drug offenses to enter substance use treatment rather than the criminal justice system.
- Explore the creation of overdose prevention centers, where people take (pre-obtained) drugs in the presence of health professionals who ensure safety, education, and treatment referrals.

In short, we know what works—now the City must step up to scale and sustain it.

What challenges we might encounter in executing on this initiative

All parts of it require funding. There are also legal constraints to taxing and regulating drug companies, which might be a logical revenue source. As mentioned, however, we do have a pharmaceutical representative license. More of the revenue freed up by this license could be allocated to funding the above efforts. It isn't a large amount either way, however, and we are continuing to apply for grants. In addition, overdose prevention centers face legal obstacles and potential community pushback due to NIMBY issues. Still, these centers are common in Europe and Canada, and several U.S. cities are exploring them. The other steps we mention are more urgent, though, in setting up a sensible system.

Memo Template

Name: Kirstin Chernawsky
Transition Committee: Health & Human Services

Prompt: Help build resilient communities by establishing a protocol across the city for responding to acute trauma, including immediate intervention and post-emergency support

A potential initiative: Build resilient communities through culturally and linguistically relevant, multi-year investments in immediate and long-term mental health funding including a focus on community-based sites and services.

Need in the Latinx Community: National community-based surveys have demonstrated that trauma is a prevalent part of our social reality. While trauma affects people of all classes and ethnicities, low-income communities of color disproportionately experience poverty, abuse, community violence, neglect, and household dysfunction, all of which are classified as traumatic experiences. Research by Salud America demonstrates that 78% of Latinx youth suffer at least one traumatic childhood experience while 28% experience four or more traumas. Trauma can result from various factors such as the culture and climate at local schools, families' socio-economic status, immigration status, and domestic violence, among other factors.

Latinx families throughout Chicago face a range of structural barriers in accessing quality mental health services including limited access to bilingual and culturally appropriate mental health support, affordable health care, and a reduction of mental health services and programs due to funding cuts. Within this, a 2018 report by the Collaborative for Community Wellness highlights that mental health treatment options have been severely limited for those living under high economic hardship and are under/uninsured, as mental health clinics operated by the Chicago Department of Public Health have decreased from 12 to 5 since 2012. As an example, the Sinai Community Health Survey 2.0 shows the need for mental health services in Little Village (LV) is exceptionally high due to the closing of two mental health providers in recent years. The survey shows that women in LV have an average number of 4.7 mentally unhealthy days per month (the highest in Chicago) while men in LV have an average number of 3.2 mentally unhealthy days per month (second highest in Chicago).

Values Based Approach: The current inequity of Chicago's mental health resources is vivid when comparing the services available in Southwest Chicago versus more affluent neighborhoods. The Near North (Gold Coast; two community areas) has 381 clinicians, or 4.45 per 1,000 residents whereas the Southwest Side (10 community areas) has 63 clinicians, or just 0.17 per 1,000 residents.

Equitable investment in mental health therapy and resources across neighborhoods, with an emphasis on community-based solutions, would demonstrate the administration's commitment to **equity**. This initiative could be truly **transformative** if done through the lens of **diverse and inclusive** cross-sector collaboration with universities and hospitals sharing resources with community-based organizations as providers of care. To ensure **transparency, accountability**, progress and outcomes, all data should be shared across government departments and databases while also being made available to the public.

What is happening today that we need to keep

- Illinois' Family Advocacy Centers under the Department of Children and Family Services (DCFS)

What we need to implement in the next 100 days

- A steering committee – with subcommittees comprised of civic, private, nonprofit and resident groups within geographic focus areas - to help audit services that already exist, collaborate on need, and propose policy and plans targeted at identified gaps and public / private funding strategies focused on prevention and intervention initiatives.
- Respond to Inspector General's gang database report, through a lens of community healing, and work with community advocates to rollout new restorative initiatives to rectify the system moving forward and address historic inequities, disadvantages and trauma.

What we can plan for longer-term implementation

- Prioritize funding community-based mental health care (both crisis intervention and long-term care). In order to ensure equity and a commitment to the administration's overall values, build-in a corresponding scoring grid (i.e. additional points for a majority POC leadership team, a board that reflects the community, etc.).
- Prioritize funding nonprofit organizations to become fully trauma-informed in the implementation and delivery of all community programming.
- Prioritize investment in nonprofit frontline staff that serve as first responders (teachers, social workers, case managers, attorneys, etc.) as well as participants and community residents in receiving intervention and long-term mental health services and resources.
- Advocate with the state and federal government to ensure that eligibility and access to resources is not unintentionally undermined by ad hoc progress (i.e. minimum wage increase causing folks in-need of services to no longer meet eligibility requirements).
- Ensure that all city contracts allocate enough resources to pay staff at least the minimum wage (to ensure staff retention and avoid harmful disruption of services from a trusted provider) and fund agency overhead to ensure all staff receive ongoing training and best available resources.

What challenges we might encounter in executing on this initiative

- Mayor-elect Lightfoot's office will need to help shape the narrative on why substantial investment is needed for culturally competent, trauma-informed mental health resources for both preventing a host of long-term challenges but also in intervening in immediate crisis.

April 15, 2019

TO: The Honorable Lori Lightfoot, Mayor Elect

FROM: Karen G. Foley, President & CEO, Juvenile Protective Association (JPA)

RE: Health & Human Services Transition Committee Recommendation

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Topic Selected:

Define and operationalize the optimal role for the Chicago Department of Public Health

Proposed Initiative:

The Chicago Department of Public Health should adopt and promote the standards of care outlined in the recent court decision *Wit v. United Behavioral Health, 2019,* to ensure its practices and those of other agencies and organizational partners adhere to the ruling.

What is happening today?

Earlier this year, a federal court found United Behavioral Health (UBH) violated generally accepted standards of care that emphasized cost-cutting guidelines and illegally denied mental health and substance use coverage "based as much or more on its own bottom line as on the interest of the plan members…" (1) Importantly, the ruling defined effective treatment to "require treatment of the individual's underlying conditions," not merely to remediate current symptoms. The ruling precluded insurers from denying claims where treatment is necessary to prevent further medical deterioration even if the patient has plateaued and no further improvement is expected. (2) This ruling is a major step in providing parity for mental health and substance abuse care, issues that cut across social and economic sectors and disproportionally affect the poor and minority citizens of our city.

This ruling is particularly important to vulnerable populations including veterans, children, people with disabilities, the poor, individuals struggling with addictions including opioids, and first responders.

What we need to implement:

1. Create a communication campaign so the public understands their rights under the law.

2. Collaborate with the governor's office to ensure that medical licensing boards in Illinois are not dominated by insurance advocates and representatives.

3. Train 311 workers to record citizens' concerns when their claims for rightful mental health treatments are denied.

4. Invite public and private insurers to engage in strategies to ensure: the law is being following; insurers have a voice in promoting innovative preventive care; and cost: benefit analyses and practices are developed in a transparent fashion.

Plans for longer-term implementation

1. Invest in mental health services for front-line public-sector workers to ensure they are well so they can care for others.

2. Work with Chicago Public Schools to invest in strategies in school-based settings because that is where the kids are. Almost half a million children under the age of 18 live in Chicago (18% of the population).(3) Providing mental health

programming for children, educators and parents in schools will help normalize accessing mental health services and improve access and participation. Children who develop social-emotional capabilities are more resilient, and they are less likely to engage in risky and self-defeating behaviors that strain public health and other city resources as they get older.

3. Develop adult education and offer on-going support in all spheres where public employees work with or care for children and vulnerable populations. Too often social-emotional learning (SEL) programs are focused on short-term or compliance-based interventions to "fix" behaviors rather than helping vulnerable people develop the skills and strategies they need to learn and thrive, such as self-regulation, confidence, and social and peer skills. These measures will begin to address the unfortunate labeling of children and vulnerable adults as "defiant," "disrespectful," "disobedient," or "disruptive" and will begin to decrease reliance on harsh "consequences" or short-term interventions that do not address the root cause of challenging behaviors.

4. Sponsor information fairs to attract more people of color and more men into the field of social work.

5. Partner with local nonprofits who are trusted partners in the communities they serve to expand services and more effectively share messages and information with community residents on mental wellness.

6. Resist current calls to centralize services through large providers only. Research shows that many people in underserved communities do not visit mental health clinics and when they do, they attend only for a few sessions (4). Allow Chicagoans choice in where they access mental health services and supports.

7. The Chicago Department of Health should conduct and make public an audit of denied claims.

Challenges:

1. Legal challenges are likely to be launched that may undermine the ruling and lead to new restrictions on mental health services.

2. The need for mental health services outstrips our city's ability to respond. To alleviate this systemic problem: a) build capacity by bringing more people into the field; b) expand programs that help adults better care for and support children and vulnerable populations, especially those impacted by trauma, abuse and neglect, so that the entire burden of care does not fall on mental health practitioners or first responders; and, 3) expand preventative mental health programs in early childhood development centers, Pre-Ks and elementary schools.

3. Avoid insistence on narrow "evidence based" models that preclude effective real-world practices. (5)

Sources:

(1) Chicago, Daily Law Bulletin, March 20, 2019, Mark D. DeBofsky
(2) Psychotherapy Action Network website, 2019
(3) U.S. Census Bureau, 2010
(4) Jaycox et al, 2010, Gopalan, J Can Academy Child Adolescent Psychiatry, 19:3, August 2010
(5) Shedler, 2011; Blatt & Zuroff, 2005; Norcross, 2000

EverThrive Illinois
Champions for Healthy Communities

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To: Mayor-Elect Lori Lightfoot
From: Kathy Waligora, Interim Executive Director, EverThrive Illinois

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The Mayor-Elect has indicated that ensuring all Chicagoans have access to comprehensive health services, especially where data show gaps exist and where health disparities exist, is a key objective of her administration. To meet this objective, EverThrive IL recommends the following strategies to be continued or implemented by the Mayor-Elect.

What is happening today that should continue:

- Healthy Chicago 2.0 is an important and influential strategy for improving health, both the document itself and the convening, assessments, and partnerships related to developing, refining, and implementing the plan. The recent focus on health equity is particularly important.
- The City Clerk's Chicago Status of Women and Girls Working Group recently released a report entitled Chicago's New Deal for Chicago Women and Girls. The goals and strategies identified were thoughtfully developed and refined and should be supported by the Mayor-Elect. The Mayor-Elect should ensure that city resources are appropriately deployed to support the recommendations and facilitate improvement.
- The Chicago Department of Public Health hosts free flu clinics across the city each fall, through which they provide care for thousands of people. Flu clinics are supported by grants, which allow for hiring of outreach and education workers—people residing in communities where flu clinics are hosted that conduct outreach within a 5-10 block radius of clinics. These efforts reach tens of thousands of people and provide a vital public health service, which should be supported and expanded.
- Chicago Department of Public Health Walk-In immunization clinics provide vaccinations for children 0 through 18 years of age who are uninsured, uninsured, or who have public health insurance at no out-of-pocket cost. These clinics provide a critical community access point, and help to reduce demand on other safety net providers. As we see growing outbreaks of vaccine preventable disease, the city should maintain their commitment to providing vaccinations.
- The Chicago Department of Public Health convened a work group, the Coordinated Perinatal Referral System Work Group, and conducted a community assessment to identify opportunities to improve maternal and child health care in the city through a universal intervention. Over the last six months, that group has been working to shape a pilot program that would be implemented and supported by CDPH. In facilitating this work group, CDPH has been thoughtful and careful to solicit and act upon feedback from community based organizations and community members, which makes this work particularly valuable. CDPH should continue to convene this group and remain committed to facilitating this as a community driven project.

What should be implemented in the first 100 days:

- The Mayor-Elect should demonstrate her commitment to health and human services by appointing a Deputy Mayor for Health and Human Services tasked with developing and implementing a transformative vision and coordinating partnership among and between city agencies, key stakeholders, and community members.

- The city should invest in enrollment assistance for health insurance available through the Affordable Care Act, including exchange coverage and Medicaid expansion, through grants to community-based organizations or by hiring enrollment assisters as city employees. The City should also support enrollment by running coordinated public education and awareness campaigns and facilitating partnerships between enrollers and key outreach sites, like public libraries and City Colleges. Enrollment assistance has proven extremely effective for helping people to gain access to and keep affordable health insurance, while also promoting health literacy, but the federal government has cut their funding for assistance by more than 90 percent. The City of Chicago can and should be a leader by investing resources to ensure that all people who are eligible for insurance are enrolled.
- The City of Chicago does considerable work to support access to immunizations, but there are opportunities to expand and improve upon these efforts:
    - CDPH should partner with CPS to increase flu vaccination rates among parents and students by conducting outreach and education on the flu vaccine in schools and conducting flu clinics in schools.
    - CDPH should share all data on immunization rates and availability as quickly as possible and should prioritize analysis of immunization rates along key demographic indicators, including insurance status, age, and race/ethnicity.
    - CDPH Walk-In Immunization Clinics should provide services for all Chicagoans who are unable to get vaccines elsewhere, regardless of age. The clinics are currently open to people under 18 years old, but immunizing parents and other adults is critical for achieving herd immunity and protecting those who are too young to be fully vaccinated or otherwise unable to be vaccinated.
- The National Institute for Reproductive Health conducted an evaluation of city level policies related to reproductive health, summarized in their Local Reproductive Freedom Index. Chicago scores well, but the report highlights areas for improvement. The Mayor-Elect should move quickly to improve the city's score by calling for an ordinance protecting municipal employees and all workers from discrimination related to reproductive health decisions. Additionally, the Mayor-Elect should publicly support policies to oppose and regulate crisis pregnancy centers, which intimidate and misinform women who are pregnant and may be seeking abortion care.
- Despite proven success at reducing food insecurity and improving birth and developmental outcomes, participation in the Special Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC) is declining. While this program is a federal/state partnership, the City could help to drive program improvements and conduct outreach to eligible families. The City should meet with the key stakeholders who have been researching declining WIC participation to understand the challenges and opportunities for the City.

What should be implemented over the long term:

- The state employee health plan is required to provide extremely comprehensive contraceptive coverage as a result of Public Act 99-0672 and comprehensive abortion coverage as a result of Public Act 100-0538, the Mayor's office should review city employee benefits to determine whether they meet these standards, and, if not, voluntarily comply with these state laws.
- CDPH should partner with the Chicago School Board and other key stakeholders to understand rates of non-medical exemption (NME) in schools and identify trends in schools which have rates of NME that put them below herd immunity for one or more vaccines.
- CDPH should establish an action plan biannually which will outline key metrics and high level strategies for increasing vaccination rates; publicly demonstrating a commitment to promoting vaccines and providing a roadmap for collaboration.

ICIRR
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April 16, 2019

To: Mayor-Elect Lori Lightfoot

From: Luvia Quiñones

RE: Health and Human Services Transition Committee 075792

Chicago is home to every wave of immigrants that have crisscrossed the nation. We welcome immigrants and peoples of all colors, as we, the City of Chicago, are a city of immigrants. We must seize the unique and crucial opportunity to continue the path of acceptance. **We must broaden and strengthen the language access ordinance to all city agencies.**

The Illinois Coalition for Immigrant and Refugee Rights (ICIRR), the state's largest multiethnic immigrant advocacy organization, is dedicated to promoting the rights of immigrants and refugees to full and equal participation in the civic, cultural, social, and political life. With more than 100-member organizations, program partners, and allies, ICIRR strives to make Chicago the most welcoming city in the nation. We are eager to work with Mayor-Elect Lightfoot's administration on policy and programmatic initiatives that welcome, protect, and empower immigrants and refugees and continue to make Chicago a model for other cities.

The U.S. health care system fuels and perpetuates pervasive health inequities based on race, ethnicity, and geography, among many other factors. Lack of access to care exacerbates health inequities, and increased coverage of populations can directly address gaps. Immigrants and their families are more likely to go without health coverage, public or private, deeply impacting their ability to obtain critical health services. The uninsured rate in Illinois and Chicago (14.2% of Chicagoans are uninsured or about 385,736[1]) has decreased greatly since the Affordable Care Act (ACA) became law but for communities of color the gains have been smaller.

According to the Healthy Chicago 2.0 report, many of the same communities that have the highest uninsured rates also have the highest number of individuals without a high school diploma and live in higher poverty: African Americans, Asians and Latinos. At the same time, immigrants have additional barriers such as language barriers and fear in accessing government services.

One initiative that can increase public health and access to integrated health services for all Chicagoans, including immigrants and refugees, is to strengthen the language access ordinance and broaden its implementation across all City agencies. According to the U.S. Census's 2017, American Community Survey, an estimated 15% (roughly 382,350 individuals) of Chicagoans qualified as limited English proficient. The top 5 languages spoken in 2017 were Spanish, Polish, Urdu, Arabic and Mandarin.

In 2015 City Council passed Mayor Emanuel's Language Access Ordinance hoping to ensure that everyone had equal access to all the available services in Chicago. Though there has been tremendous work accomplished, more work is needed to achieve this goal. Given the current national, state, and local conversations on advancing health equity, **Mayor-Elect Lightfoot has a great opportunity to tackle inequities head-on.**

Many immigrants live in families with mixed immigration statuses, such as U.S.-born citizen children residing with non-citizen parents. According to recent estimates summarized by ICIRR, of the 198,000 Illinois family households with at least one undocumented immigrant, 87% have at least one family member who is a U.S. citizen or lawful permanent resident.[1] Mixed-status families often avoid applying for health and human services, such as WIC, because they are afraid that they will be considered a public charge and that sharing information with the government might lead to an undocumented family member being deported. These families are also confused about the eligibility and enrollment requirements. This situation is particularly problematic for limited English proficient families.

Even when enrolled in a program such as WIC or other government funded programs, the quality of service and care that immigrants receive can also be deeply affected by language barriers. More than four in ten Latino immigrants report that they have difficulty communicating with health providers because of language barriers.[2] These findings are important, because positive health care outcomes increase when patients have access to language services. Patients who receive health and human services in their primary language are more likely than their counterparts who do not receive translation and interpretation services to follow their medical regimens, use more preventive health care services, and report high satisfaction.[3]

As it pertains to strengthening language access across all City agencies you need to keep the Office of New Americans and organize efforts with the Governor's Office of New Americans. These offices can play a critical role in coordinating data collection to help centralize and analyze common threads such as services used by immigrants among other things. In the next 100 days, your office can implement a task force to evaluate existing language access plans at each city agency and ask that each city agency prioritize a portion of their next budget to begin implementing its language access plans.

In the longer-term, your office can implement several policies including:

- Promote improved data collection methods to better evaluate health and human services provided to immigrant communities
- Foster best practices with community organizations to move immigrants from emergency care to primary and preventative care
- Create accountability mechanisms for current cultural and language competency requirements and establish new requirements, as necessary, to make health and human services more readily available to immigrants
- Have each city agencies prioritize a portion of their annual budgets to begin implementing its language access plans

Some challenges you might encounter in executing this initiative are resistance from staff at city agencies, lack of community engagement and funding. Many of these can be addressed by engaging every partner at all levels through meaningful conversations or town halls. Moreover, the benefits will be greater than these challenges as you can develop deeper relationships with residents and community-based organizations through improved interactions and have more strategic/coordinated use of City resources. Additionally, your office and the Office of New Americans can engage other cities with very successful language access plans such as Seattle, Los Angeles and New York City.

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[1] Tsao, Fred. 2014. "Illinois' Undocumented Immigrant Population: A Summary of Recent Research by Rob Paral and Associates. "

[2] *Health Care Experiences-2002 National Survey of Latino Experiences, op. cit.*

[3] Ku, Leighton and Timothy Waidman, *How Race, Ethnicity, Immigration Status, and Language Access Affect Health Insurance Coverage, Access to Care and Quality of Care Among the Low-Income Population. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2003*

To: Mayor-elect Lori Lightfoot
From: Lorrie Rickman Jones, Ph.D., Vice President, Strategic Innovation and Behavioral Health

Transition Committee: Health and Human Services

Potential Initiative:
Create a cabinet-level Office of Equity, Diversity and Inclusion, reporting directly to the Mayor and authorized to play a key leadership role in reducing disparities across a wide range of parameters in Chicago's communities, and in facilitating diversity and inclusion for disenfranchised populations.

How the new administration can infuse the values of equity, transparency, accountability, diversity and inclusion, and transformation in this initiative
As a health care professional, my concern has been the health and well-being of our community residents and the devastating disparities in health outcomes and mortality rates that are largely determined by the zip code one lives in, one's race or their identity. Experts in the field have come to understand that unless we address this complex social fabric that interacts with our genetics and shapes who we are, we cannot achieve the positive health outcomes we desire for all of our neighbors. For many, this social fabric has been enriching and nurturing leading to health, wealth and prosperity. But for others the experience of life in Chicago has been shaped by a deep legacy of segregation and unfair practices, fueled by policies that allowed for:

- limited access to prevention services and healthcare in communities' suffering "service deserts";
- casting Addictive Disorders as crimes in lieu of a public health approach that humanizes this brain disease and offers the needed medical care;
- underfunded and poorly resourced schools due to questionable practices in resource allocation despite the additional resources allowable for children living in poverty;
- differential meting of justice by our law enforcement community, needlessly criminalizing persons of color and those with mental health and substance use health disorders, and those policies that make their successful re-entry into their communities improbable;
- channeling money downtown and away from poor neighborhoods removing employment opportunities and leaving behind blighted neighborhoods;
- redlining policies by local banks, removing home ownership as a viable opportunity to protect families of color and transfer wealth, to name a few.

The reality for those residents that have been victim to these policies is the perpetuation of an inter-generational sense of hopelessness and early death with no visible roadmap for change.

Going forward, the well-being of all of Chicago's residents will depend on eliminating these great divides that exist between sectors of the population in health, poverty, education, employment, food security, housing, economic development, and criminal justice. **While attempting to address the "social determinants" of health is not new, most efforts have failed due to inherent limitations with an approach that is not comprehensive, holistic and systemic**. Largely state and local Departments' of Public Health and entities outside government in non-profit or academic settings have been effective in painstakingly describing the gaps and disparities. These settings also have little or no authority to create policy change in those settings contributing to those health outcomes. For example, we know that children's exposure to violence is creating a public health crisis for a community's youth who are experiencing high rates of post-traumatic stress disorder (PTSD). Truly addressing the root causes of PTSD in these youth would necessitate changes in our public-safely sector to address the violence.

Changes would also be required in the education system to bring about awareness in families so interventions can be attempted. A single system, such as a Public Health Department, would not be empowered to effect those changes. **What is required is an office that offers a systemic approach to these complex matters that can assist in setting agency priorities and track progress toward the changes that are needed.**

The creation of the Office of Equity, Diversity and Inclusion (OEDI) will achieve this objective and will signal to Chicago's residents that the important values of equity, transparency, accountability, transformation and diversity and inclusion, espoused during the election cycle, are indeed key priorities for this administration. I envision that an OEDI would work with communities, empowered with knowledge about the gaps and disparities within their communities, to establish priorities for change for their residents. OEDI would convene all agencies involved in that change and require them, collectively, to create roadmaps for addressing these community-level priorities. The OEDI would subsequently track and measure progress on these initiatives, holding each agency accountable to reporting outcomes to the Mayor and to our communities. The time is now, and the imperative is clear. The creation of this Office will be an efficient and transparent means for assessing real gaps, defining real strategies and interventions and then measuring progress and change in a transparent approach with clear accountabilities.

What is happening today that we need to keep

There is a substantial body of evidence for these inequities and disparities from a number of sources reporting data from each relevant agency. In addition, several non-profits and academic centers collect and report data on these very issues. While evidence is available, re-packaging information to create comprehensive perspectives on issues facing each community can inform community level prioritization of planned interventions. Direct involvement of community residents in the prioritization of interventions for each community creates both buy-in and will reduce the level of apathy and learned-helplessness and hopelessness many experience concerning their future and the political process.

What we need to implement in the next 100 days

Announcing and opening the Office can and should happen in the first 100 days. Beginning the process of data collection for each community across the relevant parameters as described above is a priority. Further, creating the roadmap for community engagement in the process can also be identified and the goals of the office shared with the public.

What we can plan for longer-term implementation

Once data is re-aggregated at the community level, it shall be shared with the community for input into priorities. Thereafter, planned interventions should be created at the agency level and included as budget priorities. Dashboards can be created to track progress for initiatives across the city and at the community level.

What challenges we might encounter in executing on this initiative

Creating a new office in this time of significant budget pressures could create a public relations challenge. The Office should be created using the existing headcount within the city, with each relevant agency contributing to the effort. As most of the work associated with interventions that will change the current state of our communities will occur at the agency level, the role of this office is limited to data collection, aggregation and performance monitoring. It may also be involved with convening constituencies at the community level.

Another challenge, but also an opportunity, is to create meaningful collaborations with those state and county level systems that fund many of the services that create the social structure surrounding the individual… including the healthcare and criminal justice areas. A collaboration is required to not only achieve outcomes, but to assure greater efficiency in the delivery of services, avoiding duplication of effort.

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THRESHOLDS

To: Health and Human Services Transition Committee
Chicago Department of Public Health

From: Mark Ishaug, CEO Thresholds

Date: April 15, 2019

Re: Access to Integrated Health Services and Building Resilient Communities

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Mayor-Elect Lightfoot has identified four objectives in the area of health and human services. This memo will focus on two of those goals; access to integrated health services and building resilient communities, suggesting a coordinated approach with overlapping solutions to meeting both goals.

We Need to Keep

- Healthy Chicago 2.0 Health Equity Plan's focus on racism, violence, the root causes, and social determinants of health. The recommendations for Improving Health Outcomes especially the sections titled Promoting Behavioral Health and Reducing Violence, and the mapping/data analysis that identifies at risk communities.
- Community based programs focused on preventing and addressing trauma.
- Community mental health centers that have integrated FQHCs/primary care into their behavioral health setting for those with serious mental illnesses.

Implement Immediately

- Review SAMHSA guide for integrated care models and best practices, especially for creating more behavioral health access in Federally Qualified Health Centers (FQHC). Partner with existing FQHCs to determine their infrastructure needs for increasing behavioral health (BH) services and treatment.
- Assess penetration of Mental Health First Aid for Adults and Youth in Chicago.
- Map out existing acute trauma resources and their models and create citywide plan for responding to acute trauma.
- Take best elements of Philadelphia and Newark models in creating a culture of trauma informed cities and San Francisco's Trauma Informed Community Building model.
- Partner with DFSS Flexible Housing Pool to secure subsidized units of supported housing in one community significantly impacted by trauma.
- Support of substance use treatment "outside of four walls" (currently not in SUPRA Rule).
- Support legislation that sponsors Medicaid Fee for Service rate increase for mental health providers so additional client capacity can be created.

Potential Initiative and Within the Next Year

- Create two new **Community Resilience Centers (CRC)** that would:

    - Harness and strengthen the existing successful outputs/outcomes of FQHCs and CMHCs
    - Directly intervene to address social determinants of heath, especially housing and employment (see below)
    - Be fully integrated primary care (PC)/behavioral health (BH) centers, including open access, a specific focus on trauma and BH assessments/services, BH and PC outreach, Medication Assisted Treatment (MAT) and telehealth.
    - Include the evidence based interventions of Recovery Oriented Systems of Care, Supported Employment, Supported Housing, Peer Supports, Cognitive Behavioral Therapy for Trauma, Mental Health First Aid, Trauma Informed Community Building and Wellness Action Recovery Planning.
- Coordinate between CDPH and FQHCs on expansion proposals for HRSA access point grants, which create new FQHC sites, to ensure mutual goals are achieved.
- Incentivize Behavioral Health integration in FQHC's with funding for creating open access for BH needs (Medication Assisted Treatment and psychiatry, telehealth)
- Partner with DFSS Flexible Housing Pool to secure subsidized units of supported housing in one community significantly impacted by trauma.
- Pilot supported employment effort within one community significantly impacted by trauma.

Longer Term Goals

- Appointment of a deputy Mayor on Health and Human Services and Housing focused on building resilient communities via integration and collaboration of City departments and external partners.
- Post a RFP for Community Resilience Center (CRC). Potential applicants could be existing integrated CMHC/PC providers or those willing to partner to create an integrated model.
- Leverage funding for CRC via foundations, HRSA, and Corporation for Supportive Housing.
- Increase number of behavioral health and MAT encounters at four FQHCs. These FQHCs complete universal trauma assessments and brief trauma intervention.
- Implement city-wide response to acute trauma.
- Develop plan to increase penetration of, and sustain Mental Health First Aid.

Value Infusion

The planning and development of the two proposed Community Resilience Centers will:

- Be data driven integrating existing available community needs data/assessment
- Be developed with meaningful community input
- Include an advisory committee of community members to ensure equitable participation
- Establish outcomes prior to CRC implementation with a timeframe for performance review
- Hire staff from CRC community especially those with lived experience

Challenges

- Creating braided funding streams to finance CRCs
- Redistribution of City resources

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THRESHOLDS

To: Health and Human Services Transition Committee
Chicago Department of Public Health

From: Mark Ishaug, CEO Thresholds

Date: April 15, 2019

Re: Co-Response and Second Response with the Chicago Police Department and the Chicago Fire Department

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Potential Initiative – In partnership with the CPD and CFD, develop a Co-Responder and Second Responder Model to assist and support the City of Chicago's First Responders interventions with people who are in crisis for behavioral health reasons.

Value Infusion – Chicago Police Department's Crisis Intervention Program will provide the oversight. The CIT Program staff and the behavioral health partners will share outcomes and process evaluations with the City departments, community providers and other community stakeholders. These efforts to be coordinated by data of first responders and guided by those with lived experience. To foster transparency, data sharing will be continuous between the provider and the department.

We Need to Keep

- Crisis Intervention Team (CIT) training and the Crisis Intervention Team Program staff
- Crisis Intervention Committee
- Community mental health centers that have integrated primary care into their behavioral health setting for those with serious mental illnesses
- Kennedy Forum and NAMI's community outreach and education regarding mental health
- Currently, CPD is developing co-response and second response models and we need to support additional teams and resources, including the NAMI helpline that coordinates linkage.

Next 100 Days

- Using data and best practices from co-responder models in other communities, develop protocols, interventions and expected outcomes for Chicago.
- Review models that provide follow up to high utilizers of Emergency Medical Services for behavioral health reasons. Secure resources and a process by which the city of Chicago could implement such a program.

- Partner with Federally Qualified Health Centers (FQHC) to determine their needs for increasing services and treatment of those with behavioral health issues.
- Assess penetration of Mental Health First Aid for Adults and Youth in Chicago.
- Support legislation that sponsors Medicaid FFS rate increase for mental health providers so additional client capacity can be created.
- Identify a funding mechanism or funder who will provide payment for engagement

Longer Term Goals

- Evaluate the interventions and outcomes.
- Leverage funding for additional behavioral health staff for the co-responder/second responder teams via DMH, HFS, MCOs, and Foundations.
- Increase the capacity of community behavioral services.
- Develop a plan to increase circulation of and sustain evidence based mental health awareness (including Mental Health First Aid, NAMI Chicago, in efforts to reduce emergency mental health need, reduce stigma, and increase mental health and resource literacy).
- Supported Housing

Challenges

- Securing additional funding to support the behavioral health staff for the co-responder model
- Access to mental health and substance use services
- Lack of affordable housing and supported housing

Health & Medicine
POLICY RESEARCH GROUP

Memo to the Transition Team
April 2019

Margie Schaps, Executive Director, Health & Medicine Policy Research Group

Health and Human Services Transition Committee

Prompt: Define and operationalize the optimal role for the Chicago Department of Public Health

Potential Initiative:

Building on the health equity commitment advanced in CDPH's Healthy Chicago 2.0, create an Office of Equity and Social Justice with Cabinet-level status that would have all departments represented and report directly to the Mayor.

By infusing equity, transparency, accountability, diversity, inclusion, and transformation, the initiative would ensure that all of these values are "baked into" the policies and operations of our city across departments.

As Dr. Camara Jones, the former President of the American Public Health Association says:

"Health equity is a process of assurance of the conditions for optimal health for all people. It requires at least three things: valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need. Health inequities will be eliminated when health equity is achieved."

Within the first 100 days of the Mayor's tenure, she can establish an Office of Equity and Social Justice, and begin the search for the right person to lead the team.

The Office can be modeled off of the Seattle King County office of Equity and Social Justice.

The Chicago Office should be charged with developing a strategic plan that focuses on the goal of creating a city in which structural racism and historical discrimination are squarely faced, all people have equitable opportunities to thrive, and investments are made:

- upstream where needs are greatest
- in community partnerships, and
- in employees.

And done with accountable and transparent leadership.

The Office should reflect the best of our city's shared values. Policies that are fair, inclusive, collaborative, responsive, adaptive, transparent and people focused will be positioned to address root causes that allow racist, homophobic, sexist, anti-immigrant, and religious prejudice to fester without being reactive to problems and crises. In that way, instead of communities being left behind or forsaken, a better quality of life and greater prosperity in all of our communities will be front and center.

After the first 100 days, the Office should be tasked with developing tools and resources to guide the city's agencies. The Office will be responsible for conducting an Equity Impact Review tool to identify, evaluate and communicate the potential

impact of a policy or program on equity. Other tools can include a community engagement guide, translation and interpretation resources, and an implicit bias toolkit.

So many of the city's thorniest problems can be addressed through cross-department collaborations and shared values that are examined and developed through an equity-in-all-policies approach.

- **Violence prevention**: The policy will allow for the recognition that to address violence in our city we need to collectively work on strategies in public health, education, restorative justice, policing, and housing.
- **Lead:** The policy will demand coordination to address lead paint in housing (the leading cause of lead poisoning and addressed in part through proactive housing inspections) between the health department, the housing department and the Chicago Department of Family Support Services.
- **Making Chicago a "livable city for all":** New York in particular has committed itself to becoming an age-friendly city, thereby a livable city for all residents. This involves policy and program development collaboratively created by the department on aging, disability, transportation, streets and sanitation, public health and housing.
- **Supporting people returning from prison to thrive**: The vast majority of people released from prison are returning to primarily the most disinvested communities in our city. To support these individuals, collaboration between housing, workforce development, community development, CPD, and public health at a minimum will be required.
- **Compassion fatigue and worker burn out**: First responders, healthcare workers, teachers, police and other public and private workers are suffering, burning out, and committing suicide at alarming rates. Responding to their trauma is critical and will require a collaboration between public health, family and support services, education, CPD, and others.
- **Workforce readiness:** We have growing needs for a well-educated and prepared workforce and we are not producing the diverse quantity or quality of people ready to serve in many of the available jobs. We need a coordinated, creative set of policies that will require investment and collaboration between education, workforce development, and transportation.
- **Becoming a trauma-informed city:** CDPH has taken bold steps toward creating a trauma-informed city. These efforts to modify both policy and program must be supported and expanded throughout all city departments.
- **Economic development in Chicago's neighborhoods:** Addressing economic development will require an appreciation of innovative assets-based research by the transportation, economic development, workforce development departments and more.
- **Regional leadership around critical issues (Great Lakes, economy, etc.):** The city faces regional challenges such as demographic shifts of people of color leaving the city, regional transportation coordination, and public health imperatives that cross city/county boundaries.

These are just a few of the issues facing our city where solutions and remediation will be most successful if we take an equity lens to policy development and if we require departments to work collaboratively and with community voices at the table.

Challenges: Taking an equity-in-all-policies approach to improving the health and vitality of all residents and communities will be threatening to the status quo. It will inevitably require allocating TIF and other public funding in new ways. It will require departments that haven't worked together to address problems collectively and this will be uncomfortable.

Health & Medicine Policy Research Group stands ready to assist the new administration to implement this and other health and human service reforms.

TO: Mayor-Elect Lori Lightfoot

FROM: Nancy C. Loeb

PROPMPT: Eliminating Lead in the City's Drinking Water

Across the city, Chicago's children are being poisoned by lead in the water they drink. Lead service lines – partly owned by the city and partly owned by property owners - that deliver drinking water to homes and buildings are significant contributors to this problem. Lead service lines were mandated by the city's building code until 1986 and these lead service lines remain in place across the city, particularly in lower income neighborhoods, where the cost of service line replacement is unaffordable for most residents. Lead contamination from service lines has been worsened in recent years by the city's replacement of water mains and installation of water meters, which have loosened protective coatings in pipes and allowed lead to erode into drinking water as it is distributed to homes and buildings.

The problem of lead in drinking water can be solved by replacement of lead service lines. However, even with the highest priority, service line replacement is going to take time. The city must take initial efforts to protect children from the lead danger now.

PROPOSED INITIATIVE: Education, Testing, and Filters

Many residents of Chicago are not aware of their possible exposure to lead in drinking water and the availability of free testing. Mothers of babies and infants may not be aware of the risks of lead poisoning from mixing formula with tap water. And, free filters are only being provided to the limited number of residents where water meters were installed.

The city should promptly undertake an education campaign to inform residents of the dangers of lead in drinking water, combined with a campaign to test drinking water (both by the city and residents who are able), and to make water filters available at no c ost (or reduced cost) to low income residents. Quick follow-up blood lead level testing - and treatment for elevated BLLs - should be provided at any location where drinking water tests are above FDA bottled water standards (5 parts per billion).

INFUSING THIS INITIATIVE WITH THE MAYOR-ELECTS'S VALUES:

- **Equity –** Lead contamination is more prevalent and a greater risk in low income neighborhoods in Chicago. In addition to exposure to lead in drinking water, residents of these communities also face exposure to lead from lead paint and lead in the soils in which children play. These exposures are cumulative and the need to protect children from additional exposures is even more urgent. For this reason, while education efforts should be city-wide, resources for testing and supply of filters should be focused on the city's low-income neighborhoods, particularly where there is a higher risk of lead paint in housing and where homes and playgrounds are near highways or current or former industrial operations.

- **Transparency** – The city should create and make available on a safe drinking water website information about lead in drinking water, how to request drinking water testing, how to get and use free test kits, how to get and use free or low-cost water filters, and records of education and testing done by the city, with results published (with privacy protections). The city should consider also making the website information available through CPS and libraries.

- **Accountability** – The city should establish and publish metrics on a safe drinking water website for planned education, testing, and filter delivery. Performance against these metrics should also be published.

- **Diversity and Inclusion** – Low income neighborhoods and communities of color are at the greatest risk of lead poisoning in Chicago. The most immediate efforts of this initiative should be directed towards these communities. Community leaders should be consulted to achieve the best direction of resources and highest levels of participation.

- **Transformation** – Rapid implementation of this initiative will immediately benefit and protect the health of the city's children. Lasting transformation will require the city to develop a plan for replacement of lead service lines, focusing first on the most endangered residents.

MAKING THIS HAPPEN:

- **Keep Doing** – Continue to provide free test kits to all residents and filters to residents where water meters have been installed. But, expand free or low-cost filters to all residents of high-risk communities.

- **Needed to Implement in the Next 100 Days** – (1) Develop and roll out drinking water lead safety education plan; (2) Develop and roll out plan for city-performed testing in high risk communities; (3) To the extent feasible, begin roll out of free or low-cost filters; (4) Develop and publish lead safe drinking water website.

- **Longer-term** – Obtain funding for free filters – and replacements - for low-income residents and develop plan for continuing supply until service lines are replaced and drinking water is safe. Longer-term – replace all lead service lines and continue to educate residents about ongoing risks from plumbing and provide filters where risks are continuing.

- **Challenges** – The most immediate challenge is funding, both for this more limited initiative, for ongoing filter supply, and for lead service line replacement. For filters, the city should seek partnerships from suppliers.

Initiative: Recognize and strengthen the Chicago Department of Public Health's core mission as the reliable safety net provider for Chicago residents in need, guardian of community health, and vital force in the prevention of disease.

The Chicago Department of Public Health (CDPH) has a broad mandate encompassing a range of responsibilities, including providing mental health care to the medically indigent, preventing outbreaks of contagious diseases, assuring sanitary conditions in restaurants, and providing community health education. Yet, in recent years the City of Chicago has retreated from this mission at the expense of the most vulnerable by:

- Closing all HIV/AIDS primary care clinics;
- Closing all breast cancer screening clinics;
- Eliminating the HIV/AIDS Prevention Training Unit;
- Ending Family Case Management, a health and nutrition service that had served some 2,500 moms and kids; and
- Closing six mental health clinics and privatizing, one, leaving only five CDPH community mental health clinics.
- Eliminating WIC programs.
- Sharply reducing staffing levels of contagious disease treatment and surveillance investigators, staff responsible for interviewing those who test positive for sexually transmitted infections (STIs) to identify others who may have contracted the disease, especially pregnant women at risk of transmitting the disease to their babies with dire health consequences.
- Failing to recruit professional staff to fill essential positions.

AFSCME-represented employees serve on the frontlines of CDPH's vital work in professional, paraprofessional, technical and clerical positions. They know firsthand the damage that is done to the fabric of our city when vital public health services are diminished. As services have been cut and consolidated, staff members are increasingly left to struggle with higher caseloads and shrinking resources.

In recent years, CDPH has promoted private-sector service providers as the sole response to the city's Chicago's growing health needs. But the services CDPH provides cannot be adequately replaced by the private sector for several reasons:

CDPH is the only provider which offers services that are free of charge and readily available to the medically indigent. Other providers have sliding scales or don't provide free medication and labwork and many have long waiting lists for service.

CDPH policies and administration are publicly accountable. As a division of a public municipality, CDPH administration can be called to testify before the City Council, is subject to Freedom of Information requests, and receives input from the Chicago Community Mental Health Board, comprised of consumers and advocates.

Private provider agency pay and working conditions often lead to high turnover and short staffing. Entry-level employees at private community mental health agencies often do not receive family-sustaining wages. The low pay leads to high turnover which can compromise quality and availability of care.

A robust public health system that is well-integrated in local communities is essential to preventing the spread of disease and fostering a healthier city. Yet Chicago has moved in exactly the opposite direction—removing services from the communities most in need and jeopardizing their well-being.

To achieve its mission of safeguarding the health of all our city's residents, CDPH must return to its core mission. The growing violence in our city requires a public health response. This must include ensuring mental health assessment and treatment are available in CDPH operated mental health clinics by:

- Reopening CDPH-operated mental health clinics in neighborhoods with the greatest mental health needs;
- Invest in upgrading the physical condition of existing clinics;
- Fill staffing vacancies; and
- Promote community awareness of clinic services

Most immediately, the dismantling of CDPH STI treatment and prevention programs should be halted. Rates of sexually transmitted infections in Chicago are increasing. STIs present a grave threat to public health, and patients left untreated can transmit the disease to others. The department should restore STI services on the South Side, which is disproportionately impacted by STIs, and renew the STI service mandate to try to reach all those affected by these harmful infections. To do so it must:

- Reopen the Englewood Clinic;
- Restore STI staff to 2016 levels; and
- Recommit to STI field visits, ensuring face-to-face communication so that those afflicted know the risks of exposure and the benefits of treatment.

How the new administration can infuse the values of equity, transparency, accountability, diversity and inclusion, and transformation in this initiative: Investing in the existing publicly-run public health system, rather than outsourcing critical services to private providers, is a commitment to transparency and accountability. Reopening CDPH safety-net mental health and primary care clinics and expanding STI services in underserved neighborhoods would be a step towards a more equitable distribution of city resources and ensuring the health and wellbeing of all Chicagoans.

What is happening today that we need to keep: CDPH's five mental health clinics are the cornerstone of Chicago's mental health service landscape and serve as the safety net for our most vulnerable residents. Investing in CDPH clinics can ensure that they continue to serve as shining examples of quality, trauma-informed care that can provide a model for all.

What we need to implement in the next 100 days: In January, the City Council passed a resolution creating a task force to review options for the expansion and improvement of CDPH mental health facilities and services. The new administration should promote and facilitate this process and ensure that it has the full cooperation of CDPH leadership. In addition, the new administration should move expeditiously to enhance staff recruitment and fill current CDPH vacancies.

What we can plan for longer-term implementation: Longer-term, the city should conduct a comprehensive assessment with community input, to determine the full impact of service reductions that have occurred, identify emerging health needs, and identify where CDPH could expand to fill gaps in care.

What challenges we might encounter in executing on this initiative: The chief challenge will likely be assuring needed resources. However, the expansion of public mental health services has strong public support, as well as support from the City Council. In January 2019, the Public Mental Health Service Expansion Resolution garnered 48 cosponsors and passed unanimously.

AARP Real Possibilities in Illinois

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TO: Health and Human Services Transition Committee

FROM: Rosanna A. Márquez, President, AARP Illinois

OBJECTIVE BEING ADDRESSED: Ensure all Chicagoans have access to integrated health services, especially where data shows gaps exist

INITIATIVE: Making Chicago a Healthy, Livable Community for All Ages

Short Description:
Until now, the City of Chicago has failed to integrate the voices and needs of adults 50+ and their families across the entire spectrum of City departments and programs. The current administration virtually ignored this rapidly growing segment of the City's population in its work. The same was largely true of all of the mayoral candidates. Even Mayor-elect Lightfoot's own Public Health Policy paper makes no mention of the 50+ and their challenges (e.g., chronic illness, social isolation, financial insecurity) even as it makes multiple mention of children, youth and other groups. We believe this stems in no small part from the absence of a strong leader and advocate for the 50+ within City government.

Reversing this unfortunate situation calls for a three-pronged approach: (1) immediate appointment of a strong, top leader to serve the 50+ and their families; (2) convene community-based planning sessions with adults 50+ and key stakeholders around the provision of health and human services; and (3) fully embrace the World Health Organization's Age-Friendly City designation that the City sought and was awarded in 2012.

How would this be truly transformative?
A strong advocate and voice for the 50+, whether embedded in the Mayor's Office or as a new Executive Director of the Chicago DFSS – Senior Services with direct access to the Mayor's office (through, e.g., a Deputy Mayor for Health & Human Services), will help create an integrated, responsive and effective community-based health and social services system as it relates to the 50+.

This leader will use the tools of the Age-Friendly Network to collaborate across City Departments and build upon existing planning processes and service-delivery systems. A suggested model is the Boston Age Strong Age-Friendly Network. The result will be a richer, more responsive services system for the city's fastest growing constituency – adults 50+ and their families.

How would that differ from Chicago today?
Chicagoans 50+ neither see their concerns addressed across City Departments nor feel represented in the planning for services. Today, the City of Chicago is known, if at all, as an Age-Friendly City in name only. Both of those would change under this suggested approach.

What would be the outcome if successful?
Improved health outcomes and greater community engagement by the 50+ is one measure of success of this initiative. In addition, the City of Chicago will become a citywide, national and globally recognized Age-Friendly City that has truly

become a livable community for all Chicagoans. This in turn will also support and help implement the goals of the Healthy Chicago 2.0 initiative.

How this Initiative Addresses Key Core Values

Equity:
- Engages multicultural adults 50+ in communities, including those currently underserved, with key City and County stakeholders and community service providers to structure service provision to meet community needs.
- Eliminates geographic, financial, and cultural barriers for adults 50+ and their families attempting to access services.
- Provides culturally competent and linguistically matched services.

Transparency
- Affirmative outreach and education that is culturally and linguistically competent will improve the health literacy for the 50+ and their families and will fully inform City services and provision.

Accountability
- Community-driven priorities are set for City services that affect the 50+ and their families, then clearly communicated, and reported back on, in a clear, transparent manner.

Diversity & Inclusion
- Adults 50+ and their perspectives are included in planning and implementation across all issue areas, which is currently not the case. Ideally, their participation is of a multi-generational nature.

How to Make It Happen

What must keep going?
- Chicago DFSS – Senior Services should maintain the Executive Director or similar position in order for the city of Chicago to continue to qualify for federal funds as the designated Area Agency on Aging (AAA) for Chicago.
- The City Senior Centers and satellite centers are providing valuable and much-needed services to older adults, which contributes positively to the social determinants of health of this population. Greater participation by, and increased support for, community-based service providers through these centers should continue to be nurtured.

What needs to be implemented immediately?
- The appointment of a strong, visionary leader to drive the City's efforts on behalf of the 50+ and their families.
- Convening community-based conversations around health and human service provision that includes voices of the 50+ among the stakeholders.

What needs to be implemented later?
Moving the Chicago's Age-Friendly City work out of DFSS - Senior Services. Implementation of a livable community frame for all Chicagoans across all departments is more appropriately housed where the City's broader community development efforts are coordinated.

Potential challenges:
Overcoming an organizational culture focused on compliance and is isolated from the City's other departments will take a true commitment by the Lightfoot Administration. The Administration should instead shift its focus to a visionary, problem-solving approach, with an openness to community engagement and cross-department collaboration.

Name: Roberta Rakove, Senior Vice President Strategy and External Affairs
Sinai Health System

Transition Committee: Health and Human Services

Prompt: Integrated Health Access

Potential Initiative: City of Chicago Medicaid and Marketplace Enrollment

The City of Chicago should increase Medicaid and health insurance marketplace enrollment among eligible Chicagoans by partnering with community based organizations and health providers to integrate education and enrollment into City programs, services and sites.

How the administration can infuse the values of equity, transparency, accountability, diversity and inclusion and transformation in this initiative.

With the disinvestment by the federal government in navigators, outreach for Medicaid and ACA health insurance marketplace enrollment has been greatly diminished. This has led to confusion and missed opportunities for health care coverage for Chicagoans and particularly impacts low-income and working class communities. In addition, fears within the immigrant community that have arisen during the Trump administration have suppressed enrollment within both the undocumented community and within the immigrant community even among those with permanent resident status or people in mixed status families. The community agencies and other health care providers have been unable to maintain the same level of education and enrollment assistance throughout many communities. This initiative would reach out to multiple communities including low-income neighborhoods, communities of color, immigrant communities, and others who may not have access to information and enrollment assistance. In addition, if the City can allocate some funds to train and employ navigators from the community it will empower community members.

What is happening that we need to keep:

Health care providers such as Federally Qualified Health Centers (FQHCs), hospitals, and many community based organizations are still providing this assistance, though at a diminished capacity since funding cuts.

What we need to implement within the next 100 days:

The City of Chicago should identify its sites and programs which could offer expanded education and enrollment opportunities. These could include public libraries, CHA sites, Chicago Community Colleges, Chicago public schools, Park District facilities, aldermanic offices, summer recreation programs and other programs and sites. Working in partnership with community and health based organizations that have a successful track record in Medicaid and insurance marketplace enrollment, the City should have existing staff in these programs and sites become certified as enrollment specialists and recruit and hire additional community residents to become trained enrollment specialists. Agencies with trained navigators might also be able to base them at

times within City sites. The City should also incorporate education about enrollment and availability of enrollment assistance into all of its communication vehicles. The City should also meet with the managed care organization and insurance companies that operate on the exchange and within the Medicaid program to request funding for this program as these companies will all benefit from higher enrollment.

What can we plan for longer-term implementation:

Medicaid is ongoing enrollment and can take place immediately. The City should work with agencies to gear up these efforts during the open enrollment period on the exchange that takes place in November and December. Ideally, eventually every contact Chicago residents have with a city program or site should be viewed as an opportunity to minimally provide education on Medicaid and exchange enrollment as well as actual enrollment. The City should also provide training to selected staff within its own programs that could provide enrollment assistance.

What challenges we might encounter in executing on this initiative:

The primary challenge is funding. Also, using existing City employees to add this to their jobs could violate some labor agreements. There is also considerable concern within the immigrant community since the public charge draft rule was issued that applying for benefits could damage their legal status. Enrollment on the exchange, even with the subsidy for individuals and families between 140% and 400% of the federal poverty level still remains financially difficult for many.

Even with the broad availability of federally qualified health centers for primary care, uninsured individuals are often afraid to seek health care until they are too sick to ignore an incident or condition. Adequate coverage has been demonstrated by the success of the Medicaid expansion to not only improve access to care but also health status and outcomes. This is not a high cost option for the City and could be implemented fairly quickly.

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Transition Committee Memo

Name: Suzanne Carlberg-Racich, MSPH, PhD
Assistant Professor, Master of Public Health Program, DePaul University
Director of Research, Chicago Recovery Alliance

Transition Committee: Health and Human Services

Potential initiative: Addressing Chicago's Opioid Crisis

Values: ***Equity*** – Increasing effort and attention to communities of color, particularly African-American men who use heroin, will ensure that the population most affected by fatal overdose is receiving needed services. ***Transparency*** – Ensure all Chicagoans have access to accurate, timely information related to the epidemic and response. This needs to extend beyond the CDPH website to community-driven dissemination. Asking communities how they prefer to be informed is the first step. ***Accountability –*** Being accountable means allocating resources according to the epidemiology, involving communities in planning, and ensuring timely, accurate dissemination of outcome information to communities via their preferred methods. ***Diversity and Inclusion –*** A crucial part of diversity and inclusion is maximizing the breadth of lived experience in the planning and delivery of interventions. This diversity should extend beyond demographics to the spectrum of drug use and routes of administration. ***Transformation*** - Mayor Elect Lightfoot's framing of overdose as a racial justice issue is a good start. We need a seismic shift away from the punishing framework that disproportionately affects minority communities and creates catastrophic health inequities. Mayor Lightfoot is in a position to set the tone and address this issue with public health rather punishment. This shift can begin to mitigate deeply entrenched stigma that permeates our systems and isolates individuals from needed support.

What is happening today that we need to keep

Overdose Education & Naloxone Distribution (OEND). There is a dose-response effect with OEND, meaning the more naloxone we distribute in communities, the more lives are saved. Also, equipping people who use drugs (PWUD) with naloxone is the best use of limited funding, as PWUD are responsible for 90% of overdose reversals. Finally, twenty-plus years of distribution by the Chicago Recovery Alliance has shown that injectable, generic naloxone is the most economic choice, and that people who use drugs by routes other than injection are *receptive to and capable of* using this option.

Harm Reduction Programs with Syringe Distribution. The vast majority of individuals who use opioids are not ready for complete abstinence. Harm reduction programs offer a safe space in which to collaborate for better health. Decades of evidence has demonstrated positive outcomes including: reductions in HIV and Hepatitis transmission, reductions in the sharing of drug equipment, decreases in discarded contaminated equipment in community spaces, reductions in overdose where naloxone has been available, and increases in referrals to services, including treatment.

Opioid Agonist Therapy. Treatment with agonist medication is associated with reductions in opioid overdose mortality and all-cause mortality. These medications are also associated with a host of positive health and social outcomes. While other medication options exist, they do not have the extensive evidence base of agonist therapies, and are not associated with reductions in opioid overdose mortality.

What we need to implement in the next 100 days

Ensure that people who use drugs are at the forefront of planning and policymaking. Purposeful engagement of individuals with lived experience ensures that policies and programs are culturally relevant, necessary, and effective. To maximize participation, ensure that spaces are safe for those who face both social and legal repercussions for identifying as a person who uses illicit drugs.

Shift to person-first, non-stigmatizing language in all verbal and written communications from the Mayor's office, and encourage other city entities to do the same. Terminology such as "addict" should be abandoned, and replaced with "persons with substance use disorder", as one example.

Prioritize the evidence in any existing public health grant mechanisms. This includes prioritizing OAT programs that emphasize front-line, evidence-based medicine (Methadone, Buprenorphine) and OEND programs that focus on populations most likely to reverse overdose (PWUD).

Increase funding for harm reduction services, including syringe and paraphernalia access with HCV preventable injection. CDPH has been a critical and committed supporter of this life-saving, evidence-based work, and is responsible for saving tens of thousands of lives – all in a climate that still prohibits use of federal funds for the actual syringes.

What we can plan for longer-term implementation

Launch a stigma reduction campaign to mitigate community-level barriers to methadone expansion. Implement hub-and-spoke models to remove unnecessary barriers to methadone maintenance.

Expand alternatives to arrest, such as the CPD pilot diversion program, but ensuring immediate access to methadone and buprenorphine in addition to other options. When individuals are not ready for treatment, explore connections to harm reduction programs rather than treatment or incarceration.

Fund harm reduction shelters, harm reduction housing, and housing-first models, which recognize the need for safe space as fundamental to life and health.

Expand true peer-based community health worker OEND delivery models (employing individuals who currently use drugs) to reach individuals who are not already connected to harm reduction programs.

Recognize and respond to the intersection of trauma and the drug war. Expand supportive trauma programs such as Healing Hurt People. Consider a UMedics training for the Transition Team or city workers to better understand communities most impacted by violence.

Implement low-threshold, outreach-based health care and treatment models that mitigate challenges to entry and retention in care for a variety of health issues. Require existing city-funded treatment and care programs to minimize barriers to access and retention.

Explore new approaches in this crisis, such as outreach-based drug sample testing to prevent overdose, and overdose prevention sites as safe spaces to reduce harms and provide respectful connection points to a host of needed health and social services.

To Mayor Elect Lori Lightfoot

From Shastri “Swami” Swaminathan MD
Emeritus and Recently retired Chair of Psychiatry Advocate Illinois Masonic Medical Center

Initiative-
Complete transformation of the current woefully fragmented system of healthcare, where mental health, substance use,care of patients with chronic medical illnesses are are handled in silos contrary to all scientific
evidence.

The new administration can bring about change in the current ineffective
Mental health Carey bringing together professionals who are in the day to business of providing both in the private and public sector.

We need to keep working with the current initiatives allowed by the Expanded Mental health Services act Of 2011, to open-up new neighborhood Community Health Centers.

In the next 100 days, do a quick and dirty GAP analysis of the current
needs in our communities, with a focus on where these CHCs are needed
and start the process of educating health care providers on the need for Integrated Care, which would allow total holistic care of people w chronic mental and physical illnesses including substance use under one roof, with an EMR that can allow ALL care providers can communicate with each other
and coordinate care for our patients.

The longer term plan must include obtaining of funds thru Medicaid waivers
that have opportunities for pilots using Integrated and Collaborative Care that as the scientific literature confirms would improve access and reduce stigma.

Barriers and challenges Would be funding this project in the face of current reimbursement being for traditional fee-for-service models which continue
fragmented and siloed Care,that is expensive, and doesn’t address the access issue .

24-Hour Helpline 877.505.HOPE (4673)
GatewayFoundation.org

Dear Mayor Elect Lightfoot –

On behalf of the entire Gateway Foundation family, thank you for the invitation to participate in your Public Health and Human Services Transition Team. It is an honor to provide input on the important work you are planning to improve the health of all Chicago residents.

The Problem:

The City of Chicago, State of Illinois and the nation are experiencing a pandemic of overdose and addiction. At 796 deaths in 2017, there were more deaths in the city from drug overdose than gun violence or motor vehicle crashes. Chicago led the nation in emergency room overdose admissions with a 74% increase in deaths from 2015-2017, despite concerted efforts to reduce substance use in the city. Substance misuse is central to all health and social justice issues including non-representative incarceration, mental illness, poverty, crime, medical disease and access to equitable resources. Federal data indicates that of over 250,000 people in need of substance use treatment in Chicago, only 25,000 receive treatment. Those living in poverty have the least access to care. Gateway Foundation, despite its extensive treatment network, manages an active waitlist of over 600 Chicago area residents, many of whom are suffering death and incarceration as a result of untreated addiction.

As the epidemic worsened, the Rauner Administration consistently reduced funding and introduced significant barriers to care with the appointment of managed care organizations that limit care despite medical necessity and delay or avoid payment to providers altogether. Gateway Foundation is owed $3 million for care delivered – and we are just one organization of many across the state with outstanding unpaid claims. This situation is not sustainable and is jeopardizing the availability of quality treatment for the people who need it most. Additionally, there is insufficient safe and affordable housing for those impacted by substance use and working to build a life of recovery. The research is clear that recovery outcomes plummet without housing, employment, education, insurance and resources. The City of Chicago needs an innovative, collaborative and transformative approach to treating addiction and overdose in order to address equity, racism, violence and justice.

The Solution:

What to keep: Healthy Chicago 2.0, community collaboratives, federally funded jail and hospital initiatives, city and county initiatives and the treatment network are making headway in reducing substance use and its effects but do not have the necessary impact to meet your objectives of equity, diversity and inclusion, accountability and transparency without additional support. Gateway Foundation receives federal State Targeted Response monies to work in Chicago hospital emergency departments, which has resulted in intervention for nearly 1,000 patients to date. Gateway Foundation's statewide network of 14 evidence-based programs has served over 14,000 individuals in 2018 alone. Our Chicago programs include two large residential treatment programs with transitional housing and three sites offering outpatient services that provide medication-assisted treatment for opioid users as well as intensive case management.

Short Term:

1. Build and launch a 6-month work group that will evaluate all substance use services, grants, hospital programs, state initiatives, county initiatives and city initiatives to facilitate a sustainable, coordinated plan that reaches all persons needing care with efficient and effective treatment intervention that includes community-based intervention. Members should represent law enforcement, providers, health systems, payers, government and those with lived experience.
2. Build and launch a 6-month work group that will partner with DHS, DOI, HFS and SUPR to investigate MCO and private insurance company behaviors that negatively impact consumers and providers and prevent access to life-saving care. Members should comprise of advocacy groups including but not limited to NAMI, Kennedy Forum, IABH and IARF to assure all voices are heard.

24-Hour Helpline 877.505.HOPE (4673)
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Members should also include representatives of each governmental oversight body and community leaders.

3. Build and launch a mobile crisis team model that goes into the community to meet substance users where they are. Chicago is fortunate to have a strong CIT program in law enforcement, harm reduction in the provider community but there is not yet a true treatment team that can deliver services in a way that would increase engagement and participation.

Long Term:

1. Evaluate all vacant city property to identify community-based resource centers that could be repurposed to offer substance use treatment and community supports to address social determinants of health including poverty, medical insurance, employment, mental health, social support, housing, education and overall wellness. Centers of this type would distinguish Chicago as a model of innovation in addressing large social problems. Gateway Foundation has a clear vision for this project that can be discussed in more detail. Project success would be dependent on a successful community collaboration of experts and a holistic approach to address all social determinants of health.
2. Addiction is not a problem exclusive to low-income residents in vulnerable communities. Substance misuse pervades the entire strata of income and race in the city, state and country. Prevention programs can be launched to directly target all members of the city populace. We can learn from existing programs, e.g. the "Get IN Chicago" project that is fully funded by philanthropy and the business community.

Equity: Chicagoans with higher income and private insurance have immediate access to high quality substance use treatment with proven outcomes and respect. Low income, uninsured or publicly insured residents face significant barriers to care, leaving them without options. They experience incarceration and homelessness and die at disproportionately high rates. It is time that the City of Chicago takes a stand. Without collaboration and investment, there will be no equity.

Transparency: Chicago must effectively communicate its strategy to increase and improve investment from all parties. We must be clear about the data behind those suffering to bring into focus the racial disparities inherent in the disease of addiction. The city can expose the practices and profits of insurers to increase the accountability of those entrusted to treat those in need.

Accountability: Providers of substance use services, like all health providers, must be held accountable to prove positive outcomes. Then the recommended initiatives above should transform the delivery system and increase access to treatment, resulting in significant decreases in overdose, under the influence motor vehicle deaths and incarceration. Gateway Foundation outcome success rates lead the field with over 90% abstinence rates for opioids, heroin, meth, amphetamines, benzodiazepines and designer drugs 12 months after treatment completion, based on an independent OMNI study of Gateway Foundation Illinois patients in 2018.

Diversity and Inclusion: In the City of Chicago, equitable access to care is a racial issue. Citizens of color experience higher rates of overdose, incarceration and poverty than the larger community. Without immediate access to quality substance use treatment, this trend will persist.

Gateway Foundation looks forward to partnering with Mayor Elect Lightfoot in transforming substance use treatment for the city. We are optimistic that through collaboration and innovation, Chicago will lead the nation in the fight against the overdose and substance use pandemic.

Dr. Thomas P. Britton,
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